

Page 1

1 UNITED STATES DISTRICT COURT
2 NORTHERN DISTRICT OF OHIO
3 EASTERN DIVISION
4 ~~~~~

5 IN RE: NATIONAL PRESCRIPTION MDL No. 2804
6 OPIATE LITIGATION

7 Case No.
8 17-md-2804

9 Judge Dan Aaron
10 Polster

11 This document relates to:

12 The County of Cuyahoga v. Purdue Pharma, L.P.
13 et al., Case No. 18-OP-45090

14 City of Cleveland, Ohio v. Purdue Pharma L.P.,
15 et al., Case No. 18-OP-45132
16 The County of Summit, Ohio, et al. v. Purdue
17 Pharma L.P., et al., Case No. 17-OP-45004

18 ~~~~~
19 Videotaped Deposition of
20 JOAN PAPP, M.D.
21 February 5, 2019
22 9:20 a.m.

23 Taken at:
24 Porter Wright Morris & Arthur LLP
25 950 Main Avenue, Suite 500
26 Cleveland, Ohio 44113

Stephen J. DeBacco, RPR

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<p>1 THE VIDEOGRAPHER: The date is 2 February 5, 2019. We're on the record at 3 a.m.</p> <p>4 This is the deposition of Dr. Joan 5 Papp in the matter of In Re: National 6 Prescription Opiate Litigation in the United 7 States District Court, Northern District of 8 Ohio, Eastern Division.</p> <p>9 Will counsel in the room please 10 state appearances for the record.</p> <p>11 MS. SCOLNICK: My name is Judy 12 Scolnick, and I am a partner at Scott & Scott. 13 We represent the Plaintiff, MetroHealth 14 Hospital, which is not a bellwether plaintiff 15 in the MDL.</p> <p>16 MS. KOUBA: Annie Kouba with Motley 17 Rice representing Plaintiffs.</p> <p>18 MS. WILSON: Robin Wilson 19 representing Plaintiff Cuyahoga County.</p> <p>20 MR. MENDELSON: Clifford 21 Mendelsohn from Tucker Ellis on behalf of 22 Janssen Pharmaceuticals and Johnson & Johnson.</p> <p>23 MR. HERMAN: Steven Herman from 24 Zuckerman Spaeder on behalf of CVS Indiana, 25 LLC, and CVS Rx Services Incorporated.</p>	<p>1 (Crosstalk.)</p> <p>2 MS. SACKS: Hi. So that's 3 Joe and -- Joseph Ciaccio and Shayna Sacks for 4 Napoli Shkolnik, Cuyahoga County.</p> <p>5 JOAN PAPP, M.D., of lawful age, called 6 for examination as provided by the Federal 7 Rules of Civil Procedure, being by me first 8 duly sworn, as hereinafter certified, deposed 9 and said as follows:</p> <p>10 EXAMINATION OF JOAN PAPP, M.D.</p> <p>11 BY MS. McNAMARA:</p> <p>12 Q. Good morning, Dr. Papp.</p> <p>13 A. Good morning.</p> <p>14 Q. Could you please state your full 15 name for the record?</p> <p>16 A. Joan Papp.</p> <p>17 Q. And what's your current address?</p> <p>18 A. My home address is 27228 19 Worthington Lane, Olmsted Falls, Ohio 44138.</p> <p>20 Q. Great. Have you ever been deposed 21 before?</p> <p>22 A. I have not.</p> <p>23 Q. Great. So I'll just start out with 24 a few simple ground rules to help it go 25 smoothly today.</p>	
<p>1 MR. MILLER: Hayden Miller from 2 Ropes & Gray on behalf of Mallinckrodt, LLC, 3 and SpecGx, LLC.</p> <p>4 MR. DAVISON: William Davison of 5 Ropes & Gray on behalf of Mallinckrodt, LLC, 6 and SpecGx, LLC.</p> <p>7 MS. McNAMARA: Colleen McNamara 8 from Williams & Connolly on behalf of Cardinal 9 Health.</p> <p>10 THE VIDEOGRAPHER: Will counsel on 11 the phone please state appearances for the 12 record.</p> <p>13 MR. HALPERN: Richard Halpern, 14 Marcus & Shapira, on behalf of HBC.</p> <p>15 MS. GATES: Lisa Gates from Jones 16 Day on behalf of Walmart.</p> <p>17 MR. LAZAR: Zachary Lazar of Morgan 18 Lewis for the Teva Defendants.</p> <p>19 MR. BADALA: Salvatore Badala, 20 Cuyahoga County.</p> <p>21 MS. HOSMER: Heather Hosmer of 22 Arnold & Porter on behalf of Endo and Par 23 Defendants.</p> <p>24 MR. CIACCIO: Joseph Ciaccio, 25 Napoli Shkolnik --</p>	<p>1 We have a court reporter who's 2 going to be taking down everything we say, so 3 it's important that we try our best not to talk 4 over each other. So I will do my best to wait 5 until you finish your answer before I start my 6 next question, and I'd appreciate if you do the 7 same for me. Fair?</p> <p>8 A. Fair.</p> <p>9 Q. And along the same lines, it can be 10 difficult to transcribe an "uh-huh" or "uh-uh," 11 so it's also important that you answer every 12 question with a full word like a "yes," "no," 13 or "okay." Fair enough?</p> <p>14 A. Yes.</p> <p>15 Q. And we will take periodic breaks 16 throughout the day, but if at any time you need 17 to take a break, just let me know and we'll do 18 that. My only request is that if there's a 19 question pending, you answer the question 20 before we go off the record. Okay?</p> <p>21 A. Okay.</p> <p>22 Q. And is there any reason that you 23 would not be able to provide truthful and 24 accurate testimony today? Any medications, 25 illness, anything?</p>	

<p style="text-align: right;">Page 14</p> <p>1 A. No.</p> <p>2 Q. Great. So you understand that you 3 are testifying today in connection with some 4 ongoing litigation, correct?</p> <p>5 A. Correct.</p> <p>6 Q. And do you know who the plaintiffs 7 are in the case in which you are testifying 8 today?</p> <p>9 A. I have reviewed the plaintiffs, 10 yes.</p> <p>11 Q. So you understand that Cuyahoga 12 County and Summit County and City of Cleveland 13 are the Plaintiffs?</p> <p>14 A. Yes.</p> <p>15 Q. Great. Do you know who the 16 Defendants are?</p> <p>17 A. The pharmaceutical companies, as 18 well as distributors.</p> <p>19 Q. And do you have an understanding of 20 the allegations in the case?</p> <p>21 A. Yes.</p> <p>22 Q. And what's your understanding?</p> <p>23 A. That misinformation was provided 24 about the addictiveness of opioids, which led 25 to overprescribing.</p>	<p style="text-align: right;">Page 16</p> <p>1 Q. -- or to MetroHealth's view on 2 anything?</p> <p>3 A. Yes, I understand.</p> <p>4 Q. So I will do my best to ask clear 5 questions that make that clear. If at any 6 point you're confused, just ask me to rephrase. 7 Okay?</p> <p>8 A. Okay.</p> <p>9 Q. Great. So I want to start by 10 talking a little bit about your professional 11 background. So I'll hand you what I've marked 12 as Exhibit 1.</p> <p>13 MS. McNAMARA: There are a bunch of 14 copies in the folder.</p> <p>15 - - - - -</p> <p>16 (Thereupon, Deposition Exhibit 1, 17 Dr. Papp Bio, CUYAH_001688134, was 18 marked for purposes of 19 identification.)</p> <p>20 - - - - -</p> <p>21 MS. SCOLNICK: Does anyone else 22 need them?</p> <p>23 Q. Do you recognize Exhibit 1?</p> <p>24 A. Yes.</p> <p>25 Q. And what is it?</p>
<p style="text-align: right;">Page 15</p> <p>1 Q. And you have an understanding of 2 the relief that's being sought in this case?</p> <p>3 A. Yes.</p> <p>4 Q. And what's your understanding?</p> <p>5 A. Damages and -- and financial 6 damages.</p> <p>7 Q. Do you know how much money is being 8 claimed in damages?</p> <p>9 A. I do not.</p> <p>10 Q. And do you know whether MetroHealth 11 has filed its own lawsuit against some of the 12 Defendants?</p> <p>13 A. Yes.</p> <p>14 Q. And do you know the status of that 15 lawsuit?</p> <p>16 A. It is ongoing.</p> <p>17 Q. And so you understand that you're 18 here today to testify in your personal capacity 19 about your own knowledge based on your 20 experience as a doctor in Cuyahoga County, 21 correct?</p> <p>22 A. Yes.</p> <p>23 Q. And you are not here to testify on 24 behalf of MetroHealth --</p> <p>25 A. Yes.</p>	<p style="text-align: right;">Page 17</p> <p>1 A. This is a bio.</p> <p>2 Q. Of you?</p> <p>3 A. Of me, correct. Yes.</p> <p>4 Q. And did you prepare this document?</p> <p>5 A. Yes, I did.</p> <p>6 Q. Okay. So it looks like, from your 7 bio, that you graduated from the Medical 8 College of Ohio in 2000; is that correct?</p> <p>9 A. Yes, that's correct.</p> <p>10 Q. And then you went to MetroHealth 11 Medical Center in Cleveland for obstetrics and 12 gynecology?</p> <p>13 A. Yes, that's correct.</p> <p>14 Q. And what was that? Was that a --</p> <p>15 A. I did one year of residency in 16 OB/GYN.</p> <p>17 Q. And then you did a residency in 18 emergency medicine, correct?</p> <p>19 A. That's correct.</p> <p>20 Q. What drew you to emergency 21 medicine?</p> <p>22 A. I enjoyed the rapid pace and caring 23 for patients, and -- that had acute medical 24 problems.</p> <p>25 Q. And you completed your residency in</p>

<p>1 2004; is that correct?</p> <p>2 A. That's correct.</p> <p>3 Q. And what did you do after you</p> <p>4 completed your residency?</p> <p>5 A. I worked for Emergency Professional</p> <p>6 Services and was employed both at the Cleveland</p> <p>7 Clinic at Lakewood, and also at Lutheran. We</p> <p>8 worked through a contractor, EPS. I worked</p> <p>9 there until 2007.</p> <p>10 Q. And in 2007 you joined MetroHealth?</p> <p>11 A. I joined MetroHealth as a staff</p> <p>12 physician, that's correct.</p> <p>13 Q. And just to back up for a second</p> <p>14 because we'll be mentioning MetroHealth today,</p> <p>15 MetroHealth is a hospital system, correct?</p> <p>16 A. Yes.</p> <p>17 Q. And so what's the structure of</p> <p>18 MetroHealth? Is there a central hospital and</p> <p>19 then satellite facilities?</p> <p>20 MS. SCOLNICK: I'm going to object.</p> <p>21 Beyond the scope of the deposition.</p> <p>22 But you can answer.</p> <p>23 A. It's -- there's a main campus</p> <p>24 hospital, and there are satellite hospitals.</p> <p>25 Q. And you work at the main campus?</p>	<p>Page 18</p> <p>1 A. We -- we care for any patients who</p> <p>2 come through our doors.</p> <p>3 Q. But mostly Cuyahoga County</p> <p>4 residents?</p> <p>5 A. Primarily, just based on our</p> <p>6 location.</p> <p>7 Q. And have you focused on emergency</p> <p>8 medicine the whole time since you joined</p> <p>9 MetroHealth in 2007?</p> <p>10 A. Since 2007 I have been an emergency</p> <p>11 physician at MetroHealth.</p> <p>12 Q. And have your duties and</p> <p>13 responsibilities changed over the years since</p> <p>14 you joined?</p> <p>15 A. Yes, they have.</p> <p>16 Q. Great. So let's start at the</p> <p>17 beginning and just kind of walk through</p> <p>18 chronologically.</p> <p>19 A. Sure.</p> <p>20 Q. So you joined as an emergen- -- as</p> <p>21 a staff physician in the emergency department?</p> <p>22 A. That's correct.</p> <p>23 Q. And what were your responsibilities</p> <p>24 in that capacity?</p> <p>25 A. Clinical care of emergency</p>
<p>1 A. I primarily work at the main</p> <p>2 campus. I do occasionally do emergency</p> <p>3 department shifts at satellite emergency</p> <p>4 departments.</p> <p>5 Q. Do you know approximately how many</p> <p>6 licensed prescribers are staff members at</p> <p>7 MetroHealth?</p> <p>8 MS. SCOLNICK: The same objection</p> <p>9 and same instruction.</p> <p>10 You can answer.</p> <p>11 THE WITNESS: Okay.</p> <p>12 A. There are about 950 staff medical</p> <p>13 providers.</p> <p>14 Q. And what's the geographic scope of</p> <p>15 the patients you serve at MetroHealth?</p> <p>16 MS. SCOLNICK: Objection. The same</p> <p>17 objection. It's beyond the scope.</p> <p>18 Q. You can answer.</p> <p>19 MS. SCOLNICK: And you can answer.</p> <p>20 A. Cuyahoga County.</p> <p>21 Q. Do you serve any residents of</p> <p>22 Summit County as well?</p> <p>23 MS. SCOLNICK: Objection. The same</p> <p>24 objection.</p> <p>25 You can answer.</p>	<p>Page 19</p> <p>1 department patients. There's also teaching</p> <p>2 responsibilities with medical students and</p> <p>3 residents, and a small percentage of my time</p> <p>4 was dedicated to administrative duties.</p> <p>5 Q. And for how long did you hold that</p> <p>6 role as a staff physician in the emergency</p> <p>7 department?</p> <p>8 A. Well, I -- it's an ongoing</p> <p>9 position, so I continue in that capacity. But</p> <p>10 my role changed, and I took on additional</p> <p>11 duties in 2012.</p> <p>12 Q. And what were those additional</p> <p>13 duties?</p> <p>14 A. I sought to develop a program to</p> <p>15 dispense naloxone to lay providers, Project</p> <p>16 DAWN.</p> <p>17 Q. And -- and you started that in 2012</p> <p>18 you said?</p> <p>19 A. I began research in program</p> <p>20 development during that time. The program</p> <p>21 didn't begin until Sep- -- excuse me -- March</p> <p>22 of 2013.</p> <p>23 Q. And when you took on responsibilities</p> <p>24 for Project DAWN, approximately how much of</p> <p>25 your time was devoted to that as opposed to</p>

<p style="text-align: right;">Page 22</p> <p>1 practicing in the emergency room?</p> <p>2 A. That's a difficult question to</p> <p>3 answer. My clinical time didn't formally</p> <p>4 change. I spent a number of hours outside of</p> <p>5 my regular clinical duties. At that time my</p> <p>6 clinical percentage was 90 percent. But I --</p> <p>7 but I spent many hours outside of those formal</p> <p>8 hours doing work around the program</p> <p>9 development.</p> <p>10 Q. Got it. So this was kind of an</p> <p>11 additional project on top of everything you</p> <p>12 were already -- you were already doing?</p> <p>13 A. It was on top of my</p> <p>14 already-assigned duties.</p> <p>15 Q. And have you taken on any other</p> <p>16 responsibilities since 2012?</p> <p>17 A. Yes.</p> <p>18 Q. And what are those?</p> <p>19 A. In 2017 we opened an Office of</p> <p>20 Opioid Safety, with the mission to improve</p> <p>21 opioid safety throughout the community and</p> <p>22 MetroHealth through education, advocacy, and</p> <p>23 treatment.</p> <p>24 Q. And that's an initiative within</p> <p>25 MetroHealth, correct?</p>	<p style="text-align: right;">Page 24</p> <p>1 made to connect that victim and family to</p> <p>2 treatment. With the support of the family, of</p> <p>3 course.</p> <p>4 Q. And I have some documents I'll show</p> <p>5 you later, so -- that might refresh your</p> <p>6 recollection on some other --</p> <p>7 A. Okay.</p> <p>8 Q. -- parts of it, so you don't have</p> <p>9 to remember.</p> <p>10 A. Okay.</p> <p>11 Q. Are there any others you can think</p> <p>12 of off the top of your head?</p> <p>13 A. Yeah. So that's one program.</p> <p>14 We have -- we've certainly expanded</p> <p>15 Project DAWN over the course of the six years</p> <p>16 that I've been functioning in this role. We</p> <p>17 have five walk-in sites. We have expanded</p> <p>18 Project DAWN to include opioid -- excuse me --</p> <p>19 naloxone distribution in the emergency</p> <p>20 department, inpatient units, and in Cleveland</p> <p>21 EMS.</p> <p>22 We also have developed a peer</p> <p>23 supporter program. We have collaborated with</p> <p>24 an outside agency called THRIVE that staffs our</p> <p>25 emergency department in other areas of our</p>
<p style="text-align: right;">Page 23</p> <p>1 A. That is correct.</p> <p>2 Q. And when you took that on, did that</p> <p>3 reduce your clinical time?</p> <p>4 A. Yes, it did.</p> <p>5 Q. By about how much percentage-wise?</p> <p>6 A. It ranges between 40 and 50</p> <p>7 percent, depending on how many programs I have</p> <p>8 going on.</p> <p>9 Q. And when in 2017 did that launch?</p> <p>10 A. July.</p> <p>11 Q. July. And have you taken on any</p> <p>12 other responsibilities since then?</p> <p>13 A. As -- as our program has developed,</p> <p>14 we have started many initiatives within the</p> <p>15 office.</p> <p>16 Q. And what are those initiatives?</p> <p>17 A. Boy, there's a lot. So I can</p> <p>18 start -- let's see. Where to start.</p> <p>19 So we have a grant that allows us</p> <p>20 to form Quick Response Teams. It's a SAMHSA</p> <p>21 Grant. And that initiative involves a social</p> <p>22 worker and a police officer who form a team and</p> <p>23 respond to opioid overdoses in the community,</p> <p>24 typically within one week, meeting with the</p> <p>25 overdose victim and family, and an attempt is</p>	<p style="text-align: right;">Page 25</p> <p>1 hospital with peer supporters. And those are</p> <p>2 individuals who are licensed by the State so</p> <p>3 that they can provide support and resources to</p> <p>4 patients who have either had an overdose in the</p> <p>5 emergency department or who are otherwise</p> <p>6 suffering from opioid use disorder. The goal</p> <p>7 is to connect them to treatment.</p> <p>8 Another initiative that we've</p> <p>9 started is our education program throughout the</p> <p>10 hospital. We have hired two full-time opioid</p> <p>11 educators in our office to help develop</p> <p>12 curriculum to educate both providers and</p> <p>13 community on just general awareness of the</p> <p>14 opioid epidemic, as well as a curriculum</p> <p>15 dedicated toward safer prescribing for staff</p> <p>16 providers in our hospital.</p> <p>17 We have a community educator that</p> <p>18 focuses more on education in the community,</p> <p>19 raising awareness of the opioid epidemic.</p> <p>20 We also received a grant from Ohio</p> <p>21 Mental Health and Addiction Services that funds</p> <p>22 a full-time case manager in our emergency</p> <p>23 department who helps us to connect patients to</p> <p>24 treatment. And she is a nurse practitioner who</p> <p>25 also is licensed to prescribe buprenorphine for</p>

<p>1 treatment of opioid use disorder.</p> <p>2 We also supported an initiative to</p> <p>3 increase access to medication-assisted</p> <p>4 treatment by -- we hosted several waiver</p> <p>5 trainings at MetroHealth and level-of-care</p> <p>6 trainings for our providers at MetroHealth.</p> <p>7 Let me think. What else?</p> <p>8 We -- I know I'm probably</p> <p>9 forgetting some really obvious ones.</p> <p>10 We have a program in the jail. We</p> <p>11 received a grant to connect inmates with</p> <p>12 treatment in the jail. This is still very</p> <p>13 early in the development phase and</p> <p>14 implementation phase, so it's not a fully</p> <p>15 developed program, but we're working to grow</p> <p>16 that program currently.</p> <p>17 I'm sure there are others. I --</p> <p>18 not jumping to the forefront of my mind right</p> <p>19 now, unfortunately.</p> <p>20 Q. No problem. Understood. So not an</p> <p>21 exclusive list.</p> <p>22 A. Not an exclusive list.</p> <p>23 Q. Fair enough. And all of those</p> <p>24 things that you've described are things that</p> <p>25 you've done since July 2017?</p>	<p>Page 26</p> <p>1 the program, I wanted to adapt the program for</p> <p>2 Cuyahoga County and expand it, and we did just</p> <p>3 that.</p> <p>4 And again, we have some walk-in</p> <p>5 sites, and we have expanded naloxone access to</p> <p>6 our inpatient units, our emergency department,</p> <p>7 and various other sites.</p> <p>8 Q. So do you recall when that pilot</p> <p>9 project in Southern Ohio was first launched?</p> <p>10 A. I believe it was 2012.</p> <p>11 Q. And when did you learn about it?</p> <p>12 A. In 2012.</p> <p>13 Q. Okay. Got it.</p> <p>14 And what made you want to adopt and</p> <p>15 expand it for Cuyahoga County?</p> <p>16 A. I had read about those programs,</p> <p>17 and they were found to be effective in other</p> <p>18 areas.</p> <p>19 Q. And naloxone is an antidote for an</p> <p>20 opiate overdose specifically, correct?</p> <p>21 A. An opioid overdose, correct.</p> <p>22 Q. And were you, at the time of 2012,</p> <p>23 as someone working in the emergency room,</p> <p>24 seeing an increase in the number of opioid</p> <p>25 overdoses that were --</p>
<p>1 A. Except for the expansion of Project</p> <p>2 DAWN. That has been ongoing since 2013.</p> <p>3 That's been a steady growth over time.</p> <p>4 Q. Got it. So aside from Project</p> <p>5 DAWN, these are all new initiatives?</p> <p>6 A. That's correct.</p> <p>7 Q. And so when you started Project</p> <p>8 DAWN, you started your initial research back in</p> <p>9 2012. It seems like there was a bit of a gap</p> <p>10 between when you started researching and when</p> <p>11 the program actually got off the ground.</p> <p>12 A. Sure.</p> <p>13 Q. Did you encounter any resistance</p> <p>14 from anyone within MetroHealth or the community</p> <p>15 to the idea of -- actually, strike that. Let</p> <p>16 me back up and just say --</p> <p>17 A. Sure.</p> <p>18 Q. -- so can you explain a little bit</p> <p>19 about what Project DAWN is?</p> <p>20 A. Sure. Project DAWN stands for</p> <p>21 "deaths avoided with naloxone." It's an opioid</p> <p>22 education and naloxone distribution program.</p> <p>23 This is a program that was initially started by</p> <p>24 the Ohio Department of Health as a pilot</p> <p>25 project in Southern Ohio. When I learned about</p>	<p>Page 27</p> <p>1 A. Yes.</p> <p>2 Q. -- happening in the community?</p> <p>3 A. Yes.</p> <p>4 Q. And so that was what made you want</p> <p>5 to bring Project DAWN to Cuyahoga County,</p> <p>6 correct?</p> <p>7 A. In part, yes.</p> <p>8 Q. And so Project DAWN trains people</p> <p>9 to administer naloxone, one of the things it</p> <p>10 does; is that accurate?</p> <p>11 MS. SCOLNICK: Object to the form.</p> <p>12 You can answer.</p> <p>13 THE WITNESS: Okay.</p> <p>14 A. Project DAWN, in the community,</p> <p>15 provides opioid education to both people who</p> <p>16 are actively using opioids and people who may</p> <p>17 be in a position to rescue them. And we</p> <p>18 educate on risk factors for overdose. We</p> <p>19 recognize -- on how to recognize an opioid</p> <p>20 overdose and how to respond to an opioid</p> <p>21 overdose with rescue breathing, and calling</p> <p>22 911, and administering naloxone. And naloxone</p> <p>23 kits are dispensed.</p> <p>24 Q. And so now to circle back to my</p> <p>25 original question that I kind of jumped ahead</p>

<p style="text-align: right;">Page 30</p> <p>1 to. When you were in the process of 2 researching the possibility of bringing Project 3 DAWN, did you encounter any resistance in the 4 community to the type of education and response 5 training that Project DAWN offers?</p> <p>6 A. Very little.</p> <p>7 Q. But some?</p> <p>8 A. It was a new concept, and so we did 9 get some public concern that perhaps this was 10 not -- not the best idea. But otherwise, we 11 got very little resistance from the medical 12 community and very little resistance from the 13 County.</p> <p>14 Q. And the public concern that you did 15 get, what did you do to respond to that?</p> <p>16 MS. SCOLNICK: Object to the form.</p> <p>17 A. We did a lot of public awareness 18 events. We spoke at libraries and we spoke 19 at -- in the community churches. All -- all 20 of -- just a variety of forums to really get 21 the message out that this was a safe and 22 effective way to manage overdoses.</p> <p>23 Q. And so to circle back for a minute 24 to your role at -- or the creation of the 25 Office of Opioid Safety at MetroHealth, what's</p>	<p style="text-align: right;">Page 32</p> <p>1 Mr. Masters wrote me an e-mail that 2 I could find that said not only is she a fact 3 witness and not representative of MetroHealth, 4 but she is also not an expert. So that's part 5 of the -- she's -- your question to me sounds 6 like it was presuming an expertise. I think 7 that was in -- the word in the question. So 8 that's the reason for my objection. It's to 9 the scope. She's not an expert. She's a fact 10 witness.</p> <p>11 MS. McNAMARA: Understood. I just 12 asked if she prescribes medication, which I 13 think is a fact question.</p> <p>14 MS. SCOLNICK: I don't think that's 15 what you asked, but she can certainly answer 16 the question that you just asked now.</p> <p>17 MS. McNAMARA: Fair enough. That 18 was my intent, so I will clarify.</p> <p>19 MS. SCOLNICK: Sure.</p> <p>20 Q. Do you prescribe medication?</p> <p>21 A. Yes, I do.</p> <p>22 Q. And what are the factors that you 23 personally consider when you are deciding 24 whether to write a prescription?</p> <p>25 A. I determine -- I take a history and</p>
<p style="text-align: right;">Page 31</p> <p>1 your role with respect to the Office of Opioid 2 Safety?</p> <p>3 A. I'm the founder and medical 4 director.</p> <p>5 Q. And do you know whose decision it 6 was to create the Office of Opioid Safety?</p> <p>7 A. My -- my responsibilities increased 8 between 2012 and 2017, and because of that I 9 approached our chief clinical officer, 10 Dr. Boulanger and requested additional time to 11 work on this effort, and he suggested that we 12 create an expanded office, including staff, to 13 support the work that I was doing.</p> <p>14 Q. And how many staff are currently in 15 the Office of Opioid Safety?</p> <p>16 A. I believe we have 15 as of now.</p> <p>17 Q. So as somebody who has practiced 18 medicine for -- for many years, you do 19 prescribe medication, correct?</p> <p>20 MS. SCOLNICK: I'm going to object 21 to that question.</p> <p>22 Do you want to go off the record?</p> <p>23 MS. McNAMARA: Do we need to?</p> <p>24 MS. SCOLNICK: I just don't want to 25 clutter up the record if we don't need to.</p>	<p style="text-align: right;">Page 33</p> <p>1 a physical examination, and I determine the 2 benefits of the medication versus the risk and 3 make a decision, based on my medical knowledge, 4 if a medication is indicated.</p> <p>5 Q. And what information do you rely on 6 to figure out the benefits of a medication?</p> <p>7 A. That's a -- kind of a very broad 8 question. Studies of effectiveness.</p> <p>9 Q. Do you rely on the FDA-approved 10 labeling?</p> <p>11 A. Yes.</p> <p>12 Q. And do you also rely on the 13 FDA-approved labeling to determine the risks?</p> <p>14 A. Yes.</p> <p>15 Q. And do you rely on any other 16 sources of information to determine the risks?</p> <p>17 A. We look to the medical literature.</p> <p>18 Q. Have you personally ever prescribed 19 an opioid?</p> <p>20 A. Yes.</p> <p>21 Q. And has the frequency with which 22 you prescribed opioids changed over time?</p> <p>23 A. Yes.</p> <p>24 Q. How so?</p> <p>25 A. I have decreased the prescribing of</p>

<p style="text-align: right;">Page 34</p> <p>1 opioids over time. 2 Q. Do you have a sense of how much 3 you've decreased? The percentage? 4 A. I don't know that number. 5 Q. When you started at MetroHealth 6 back in 2007, what was your understanding 7 regarding the appropriate circumstances to 8 prescribe an opioid? 9 A. During my training I was taught 10 that patients should not have to experience 11 pain, and that we should be very aggressive 12 about treating their pain, and that opioids 13 were a safe and effective treatment. 14 Q. And what training are you referring 15 to specifically? 16 A. My emergency medicine residency 17 training. 18 Q. And that was at MetroHealth? 19 A. That's correct. 20 Q. And when you prescribed opioids 21 back in -- in 2007, you prescribed them based 22 on your clinical judgment of the patient's 23 legitimate medical need, correct? 24 A. I did an assessment of the risks 25 and the benefits, and if the benefits</p>	<p style="text-align: right;">Page 36</p> <p>1 that opioids were addictive, correct? 2 A. I was. 3 Q. But you're -- you weren't aware of 4 the extent to which they were addictive? Am I 5 understanding correctly? 6 A. I think so. And I -- I think 7 I'm -- I was also not aware of the extent to 8 which they were causing fatal overdoses. 9 Q. And when you say "the extent to 10 which they were causing fatal overdoses," are 11 you referring to overdoses where the 12 prescription opioid was the sole cause of the 13 overdose? 14 A. I'm referring to opioid overdoses 15 in totality. 16 Q. So that would include overdoses in 17 which there were multiple drugs present, 18 including an opioid? 19 A. Correct. 20 Q. And to back up again, so we are on 21 the same page in -- terminology-wise. Opioids 22 and opiates, is there a distinction between the 23 two in your mind? 24 A. Yes. 25 Q. What's that distinction?</p>
<p style="text-align: right;">Page 35</p> <p>1 outweighed the risks, I chose to prescribe, in 2 my assessment at the time, based on the 3 information that I had. 4 Q. Has your understanding of the 5 appropriate circumstances in which to prescribe 6 an opioid changed over time? 7 A. Yes. 8 Q. How so? 9 A. I was not aware of the extent of 10 the risks associated with opioids, and so that 11 balance of risk versus benefit has changed for 12 me. 13 Q. And what information -- strike 14 that. 15 What sources of information have 16 come out since 2007 that helped change your 17 understanding? 18 A. One of the most influential 19 publications that I look back to is the CDC 20 MMWR report in 2012 that first described the 21 prescription drug opioid epidemic. I, prior to 22 that time, was not fully aware of the risks and 23 the number of opioid overdose deaths and 24 addiction that was occurring. 25 Q. So you were aware, prior to 2012,</p>	<p style="text-align: right;">Page 37</p> <p>1 A. "Opioid" is a term that encompasses 2 all medications that are either synthetic or 3 semisynthetic, or also encompasses opiates, 4 which are the naturally occurring substances of 5 the poppy plant. 6 Q. So "opioids" is the broader term? 7 A. "Opioids" is the broader term. 8 Q. Got it. 9 When you started at MetroHealth 10 back in 2007, did you follow any written 11 guidelines for the prescribing of opioids? 12 A. I wasn't aware of any either state 13 or national guidelines on safe opioid 14 prescribing at that time. 15 Q. And have you become aware of any 16 such written guidelines since then? 17 A. Yes. 18 Q. And I know there are a bunch, so 19 I'll table that and show them to you later. 20 A. Sure. 21 Q. Have you ever written a 22 prescription for opioids for a patient that you 23 did not think was medically appropriate based 24 on what you knew at the time? 25 MS. SCOLNICK: I'm going to object</p>

<p>1 to the question, to the form.</p> <p>2 A. Can you restate the question?</p> <p>3 Q. Sure. Has there ever been an 4 instance in which you wrote an opioid 5 prescription that you did not think was based 6 on legitimate medical need?</p> <p>7 A. No.</p> <p>8 Q. And you've treated patients in the 9 emergency room for the effects of an opioid 10 overdose, correct?</p> <p>11 A. Yes.</p> <p>12 Q. Is there any difference in how you 13 treat a patient who overdosed on one type of 14 opioid versus another? Say, heroin versus 15 oxycodone?</p> <p>16 A. It depends.</p> <p>17 Q. What does it depend on?</p> <p>18 A. The half-life of the medication.</p> <p>19 Q. So are there some opioids that have 20 a longer half-life than others?</p> <p>21 A. Yes.</p> <p>22 Q. And what are the ones that are on 23 the longer half-life side of the scale?</p> <p>24 A. Methadone, OxyContin.</p> <p>25 Q. And what are some of the ones with</p>	<p>Page 38</p> <p>1 Q. And have you ever run any reports 2 on that medical documentation that quantify the 3 number of overdoses from prescription opioids 4 versus illicit opioids?</p> <p>5 A. No.</p> <p>6 Q. To your knowledge, is that 7 possible?</p> <p>8 A. No.</p> <p>9 Q. Have you treated patients for any 10 other side effects of opioids?</p> <p>11 A. Yes.</p> <p>12 Q. What are those?</p> <p>13 A. Constipation. We often see 14 patients with illicit drug use who have skin 15 and soft tissue infections, other infectious 16 diseases related to injection of opioids. We 17 see oversedation. We see patients presenting 18 with withdrawal as well. And oftentimes 19 patients present with opioid use disorder 20 seeking treatment.</p> <p>21 Q. And that's all in the context of 22 the emergency room?</p> <p>23 A. That's correct.</p> <p>24 Q. Are you required to take any CMEs, 25 continuing medical education courses, in order</p>
<p>1 the shorter half-life?</p> <p>2 A. Oxycodone. Immediate release; I 3 should clarify.</p> <p>4 Q. And what's the relevance of the 5 half-life when it comes to treating an 6 overdose? Strike that.</p> <p>7 What's the relevance of the 8 half-life when it comes to how you treat an 9 overdose?</p> <p>10 A. I would observe the patient for 11 longer if the medication has a longer 12 half-life. Oftentimes we would admit a patient 13 if they have overdosed on a medication with a 14 longer half-life.</p> <p>15 Q. When you treat a patient for an 16 overdose, do you or anyone on your team attempt 17 to figure out whether the person has overdosed 18 on a prescription opioid versus an illicit 19 opioid?</p> <p>20 A. We ask the patient what medication 21 or drug they ingested.</p> <p>22 Q. And do you record the answer 23 anywhere?</p> <p>24 A. In the docu-- medical 25 documentation in the electronic health record.</p>	<p>Page 39</p> <p>1 to retain your medical license?</p> <p>2 A. No.</p> <p>3 Q. Have you opted to take any CMEs 4 since you got your medical license?</p> <p>5 A. Yes.</p> <p>6 Q. Have you taken any related to pain 7 management over the years?</p> <p>8 A. Yes.</p> <p>9 Q. And when was that?</p> <p>10 A. I don't recall the exact date.</p> <p>11 Q. Was it within the last five years?</p> <p>12 A. Yes.</p> <p>13 Q. Within the last two years?</p> <p>14 A. Yes.</p> <p>15 Q. Any pain management CMEs before 16 that?</p> <p>17 A. I don't recall.</p> <p>18 Q. Do you recall who, if anyone, 19 sponsored the pain management CME that you 20 took?</p> <p>21 A. I don't recall.</p> <p>22 Q. Have you taken any CMEs on opioid 23 prescribing?</p> <p>24 A. Yes.</p> <p>25 Q. And when was that?</p>

<p>1 A. Within the same time frame. I 2 don't recall exact dates.</p> <p>3 Q. And just to circle back for a 4 second to the pain management, was that an 5 in-person class?</p> <p>6 A. I have attended both inpatient 7 [sic] and online courses.</p> <p>8 Q. And was the in-person class at 9 MetroHealth?</p> <p>10 A. No.</p> <p>11 Q. Where was it?</p> <p>12 A. I took a class at -- it was in 13 Columbus as part of the American College of 14 Emergency Physicians.</p> <p>15 Q. And the opioid prescribing CMEs -- 16 CME, was that in person?</p> <p>17 A. I had both in-person and online 18 training.</p> <p>19 Q. And where was the in-person 20 training held?</p> <p>21 A. We held a SCOPE of Pain course 22 at -- at MetroHealth, although it was actually 23 off campus, but we -- we hosted a SCOPE of Pain 24 training. That was a live training. And I 25 also did the same SCOPE of Pain training online</p>	<p>Page 42</p> <p>1 A. It's a CME lecture for medical 2 staff, residents, and medical students.</p> <p>3 Q. And you mentioned early on, when we 4 started talking about your background, that you 5 had some teaching responsibilities for medical 6 students?</p> <p>7 A. Correct.</p> <p>8 Q. And you've done that since you 9 started at MetroHealth in 2007?</p> <p>10 A. Yes.</p> <p>11 Q. And in addition to grand rounds 12 courses, what else do you teach?</p> <p>13 A. We do bedside teaching with medical 14 students and residents. We do brief lectures 15 during shifts. We have more formal education 16 on Wednesday mornings, one-hour lectures. I've 17 often been requested to speak to other 18 departments in my hospital on a variety of 19 topics, including opioid-related issues.</p> <p>20 Q. Are you aware that Cuyahoga County 21 has an opiate task force?</p> <p>22 A. Yes.</p> <p>23 Q. For how long have you known about 24 the opiate task force in Cuyahoga County?</p> <p>25 A. Since 2012.</p>
<p>1 as well.</p> <p>2 Q. And do you recall who presented or 3 who taught the SCOPE of Pain course?</p> <p>4 A. I don't remember his name off the 5 top of my head. If you know it --</p> <p>6 Q. I don't. I don't. But if it pops 7 into your head.</p> <p>8 Have you ever taken a CME on 9 preventing diversion of controlled substances?</p> <p>10 A. I'm sorry. Could you repeat one 11 more time?</p> <p>12 Q. Sure. Have you ever taken a CME on 13 preventing diversion of controlled substances?</p> <p>14 A. Not that I recall.</p> <p>15 Q. Have you taught any CMEs?</p> <p>16 A. Yes.</p> <p>17 Q. And what were the subject of those?</p> <p>18 A. Let me think. Naloxone, 19 distribution and benefits of lay-access 20 naloxone. I've given lectures and grand rounds 21 to the residents and medical students on the 22 opioid epidemic. I've also given grand rounds 23 and other lectures to medical students on other 24 topics outside of the opioid crisis.</p> <p>25 Q. And what are grand rounds?</p>	<p>Page 43</p> <p>1 Q. How did you learn about it?</p> <p>2 A. I met the supervisor and director 3 of that task force, Vince Caraffi.</p> <p>4 Q. Are you a member -- are you 5 currently a member of the opiate task force?</p> <p>6 A. Yes.</p> <p>7 Q. Are you on any committees within 8 the opiate task force?</p> <p>9 A. No.</p> <p>10 Q. And have you been a member since 11 2012?</p> <p>12 A. Yes.</p> <p>13 Q. And is Project DAWN affiliated with 14 the opiate task force in any way?</p> <p>15 A. We -- let me think if we've had 16 any.</p> <p>17 Well, we do have Project DAWN -- 18 one of our -- one of our sites is at the county 19 board of health at the Parma location, and I've 20 collaborated with Vince Caraffi at various 21 times throughout the years to support our 22 program.</p> <p>23 Q. On Project DAWN, what makes up -- 24 strike that.</p> <p>25 How is Project DAWN funded?</p>

12 (Pages 42 - 45)

<p style="text-align: right;">Page 46</p> <p>1 A. We have a variety of funding 2 streams, and it's changed over the course of 3 the past six years. 4 We have funding through 5 MetroHealth. We originally received some money 6 from Ohio Department of Health. We've received 7 money from Cuyahoga County. Currently, we 8 have, additionally, a variety of funding 9 sources: Money from the ADAMHS Board, money 10 through the SAMHSA Grant, and I believe we 11 still have some funding from Ohio Department of 12 Health as well.</p> <p>13 Q. Do you know an approximate 14 percentage of -- or what percentage of funding 15 for Project DAWN comes from Cuyahoga County?</p> <p>16 A. I don't recall.</p> <p>17 Q. Is it less than 25 percent?</p> <p>18 A. I couldn't state that with 19 confidence.</p> <p>20 Q. And what does the funding for 21 Project DAWN cover?</p> <p>22 A. It covers naloxone. To some degree 23 it covers staffing. It covers kits, which 24 include a bag, some printed materials, airway 25 barrier masks for rescue breathing, and other</p>	<p style="text-align: right;">Page 48</p> <p>1 Q. Yep. Got it. 2 A. -- Opioid Hospital Consortium, I 3 think. Yeah, that's right. And I serve on the 4 executive leadership committee. 5 I am also the chair of the Ohio 6 Hospital Association Opioid Response 7 Initiative. 8 Within MetroHealth, I serve on two 9 committees. I chair two committees. One is 10 our opioid safety task force, and the second is 11 our controlled substance peer-review committee. 12 I think that's it.</p> <p>13 Q. Okay. I wanted to make sure you 14 were done.</p> <p>15 So to circle back to the U.S. 16 attorney's opiate task force, when did that 17 start?</p> <p>18 A. 2015.</p> <p>19 Q. And when did you join?</p> <p>20 A. At its inception.</p> <p>21 Q. And how did that come about?</p> <p>22 A. The U.S. Attorney, at the time, 23 convened a group of local stakeholders with the 24 purpose of delivering a conference on heroin 25 awareness.</p>
<p style="text-align: right;">Page 47</p> <p>1 promotional materials. 2 Q. So does Project DAWN purchase the 3 naloxone? 4 A. We purchase most of the naloxone, 5 yes. Some is supplied to us from other 6 sources, like the Ohio Department of Health. 7 Q. So some is -- is given; the rest 8 you purchase? 9 A. Correct. 10 Q. And from where do you purchase it? 11 A. Through our pharmacy department at 12 MetroHealth. 13 Q. Aside from -- well, aside from 14 Project DAWN, are you involved with any other 15 specific opiate task force initiatives? 16 A. Yes. 17 Q. What are those? 18 A. U.S. attorney's heroin task force. 19 I am a member, and I chair the policy 20 subcommittee. 21 I am also a member of the hospital 22 consortium. I'm not sure. The exact title 23 is -- 24 Q. Northeast Ohio -- 25 A. Northeast Ohio --</p>	<p style="text-align: right;">Page 49</p> <p>1 Q. And that conference happened in 2 2013? 3 A. That's correct. 4 Q. And did the task force continue on 5 after the conference? 6 A. Yes, it did. 7 Q. And have there been any other areas 8 of focus for the task force since 2013? 9 A. Sure. After the conference we 10 developed a community action plan developed 11 around some prior --- priority areas: 12 education, treatment, law enforcement, and 13 policy. 14 Q. And you were specifically involved 15 in the policy section? 16 A. Yes, that's correct. 17 Q. And were there -- what were the -- 18 strike that. 19 Were there any specific policies 20 that -- that your subcommittee focused on over 21 the years? 22 A. Yes. Initially, we focused on 23 expansion of naloxone. We lobbied to support 24 state law that would expand access to naloxone. 25 Q. Any others?</p>

<p style="text-align: right;">Page 50</p> <p>1 A. We supported the Good Samaritan 2 legislation. We also worked with the medical 3 board to provide feedback on medical board 4 rules around office-based opioid treatments. 5 And we also collaborated with other lawmakers 6 on a variety of local and federal policy.</p> <p>7 Q. Were there any -- have there been 8 any policies that your subcommittee has opposed 9 over the years?</p> <p>10 A. I don't recall.</p> <p>11 Q. And was it the U.S. attorney in 12 Cleveland who convened the task force?</p> <p>13 A. Yes, that's correct.</p> <p>14 Q. And do you have a sense of the 15 geographic area that's encompassed by the 16 activities of the task force?</p> <p>17 A. It includes the Northern District 18 of Ohio, which is the jurisdiction of the U.S. 19 attorney. That's much broader than the 20 practical group that met. We tended to be 21 folks from Northeast Ohio.</p> <p>22 Q. But it was intended to cover an 23 area broader than just, say, Cuyahoga County 24 and Cleveland; is that fair?</p> <p>25 A. I -- I think others from Western</p>	<p style="text-align: right;">Page 52</p> <p>1 Q. And why education for nurses? 2 A. That's an area that largely has not 3 been focused on in the past, and we felt that 4 that was a gap that needed to be filled.</p> <p>5 Q. Are nurses able to prescribe 6 opioids?</p> <p>7 A. No.</p> <p>8 Q. So the -- was the education related 9 to treatment of --</p> <p>10 A. It was related to recognizing signs 11 of opioid misuse, abuse, and other side 12 effects.</p> <p>13 Q. You also mentioned --</p> <p>14 MS. McNAMARA: Oh, do you want to 15 take --</p> <p>16 MS. SCOLNICK: Just say on the 17 record we've been at it for about an hour, and 18 I was asking the witness if she wants a break.</p> <p>19 MS. McNAMARA: Okay.</p> <p>20 MS. SCOLNICK: Do you?</p> <p>21 Because -- do you want to finish an 22 area? I don't want to interrupt if no one's 23 tired, but --</p> <p>24 MS. McNAMARA: I was just going to 25 ask about the Ohio Hospital Association, and</p>
<p style="text-align: right;">Page 51</p> <p>1 Ohio were also invited to attend and 2 participated as needed.</p> <p>3 Q. You also mentioned the Northeast 4 Ohio Opioid Hospital Consortium?</p> <p>5 A. Yes, that's correct.</p> <p>6 Q. What is that?</p> <p>7 A. It is a consortium of local 8 hospital leaders who have convened to address 9 the opioid crisis, as best served by hospital 10 systems.</p> <p>11 Q. When was that formed?</p> <p>12 A. I believe that was 2016 or 2017? I 13 don't recall the exact date.</p> <p>14 Q. Within the last couple years?</p> <p>15 A. Yes.</p> <p>16 Q. And have you been involved since 17 the start of that?</p> <p>18 A. Yes.</p> <p>19 Q. And are there any specific 20 initiatives or aspects of the opioid crisis 21 that the consortium has focused on?</p> <p>22 A. Yes.</p> <p>23 Q. What are those?</p> <p>24 A. Education for nurses and naloxone 25 access in hospitals.</p>	<p style="text-align: right;">Page 53</p> <p>1 then I'm -- then would actually be a really 2 good time.</p> <p>3 THE WITNESS: Okay.</p> <p>4 MS. SCOLNICK: Okay.</p> <p>5 Q. So you also mentioned that you were 6 the chair of the Ohio Hospital Association 7 Opioid Response Initiative?</p> <p>8 A. Yes, that's correct.</p> <p>9 Q. And what is that?</p> <p>10 A. It is an organization -- well, the 11 Ohio Hospital Association is a statewide 12 organization that serves member hospitals. The 13 opioid response initiative was formed by Paul 14 Hicks, a physician, a leader at the Ohio 15 Hospital Association.</p> <p>16 And the goal of our opioid response 17 initiative is to identify promising or known- 18 to-be-effective interventions in hospital 19 systems, and to evaluate outcomes, and 20 disseminate best practice among hospital 21 systems.</p> <p>22 Q. And when was that initiative 23 launched?</p> <p>24 A. I believe it was 2017.</p> <p>25 MS. McNAMARA: Good. Let's take a</p>

<p>1 break.</p> <p>2 THE WITNESS: Okay.</p> <p>3 MS. McNAMARA: Thank you.</p> <p>4 THE VIDEOGRAPHER: Off the record</p> <p>5 at 10:16 a.m.</p> <p>6 (A recess was taken.)</p> <p>7 THE VIDEOGRAPHER: Back on the</p> <p>8 record at 10:35 a.m.</p> <p>9 Q. Welcome back.</p> <p>10 A. Thank you.</p> <p>11 Q. Just to circle back for a moment to</p> <p>12 the Northeast Ohio Opioid Hospital Consortium.</p> <p>13 Was prescriber training part of the</p> <p>14 mission of that group?</p> <p>15 A. It has been part of the mission,</p> <p>16 yes.</p> <p>17 Q. And has the group undertaken any</p> <p>18 initiatives related to prescriber training?</p> <p>19 A. Not that I'm aware of currently.</p> <p>20 Q. Are there any plans to do so? Any</p> <p>21 current plans to do so in the future?</p> <p>22 A. Yes.</p> <p>23 Q. And what are the plans for that?</p> <p>24 A. I am not -- not aware of the</p> <p>25 immediate plans.</p>	<p>Page 54</p> <p>1 providers that it's important to educate</p> <p>2 patients to keep medications locked up and</p> <p>3 safely stored so that they are not diverted.</p> <p>4 Q. And as the -- as the doctor who's</p> <p>5 prescribing the medication, is there any way</p> <p>6 for you to know in advance of writing the</p> <p>7 prescription that it might be diverted by a</p> <p>8 family member?</p> <p>9 A. It's unlikely for me to have that</p> <p>10 information. Sometimes patients do volunteer</p> <p>11 that they have family members that have misused</p> <p>12 opioids in the past, but that's not the rule.</p> <p>13 Q. Have you, during the course of your</p> <p>14 practice and work, developed an understanding</p> <p>15 of a pharmacist's role in preventing the</p> <p>16 diversion of controlled substances?</p> <p>17 A. Yes.</p> <p>18 Q. What's your understanding of that?</p> <p>19 A. They report prescriptions to the</p> <p>20 PMP, the state PMP. They often will notify a</p> <p>21 physician directly if a prescription seems</p> <p>22 suspicious or altered.</p> <p>23 Q. Have you ever been contacted by a</p> <p>24 pharmacist about a prescription for controlled</p> <p>25 substances that you wrote?</p>
<p>Page 55</p> <p>1 Q. During the course of your practice</p> <p>2 and your work at MetroHealth, have you become</p> <p>3 familiar at all with the closed system of</p> <p>4 distribution for controlled substances?</p> <p>5 A. No.</p> <p>6 Q. Are you familiar with the term</p> <p>7 "diversion" in the context of controlled</p> <p>8 substances?</p> <p>9 A. Yes.</p> <p>10 Q. And what does that mean to you in</p> <p>11 the context of your practice and work?</p> <p>12 A. Medications being diverted from</p> <p>13 normal, prescribed legal avenues to illegal or</p> <p>14 misuse of the medications.</p> <p>15 Q. And as a doctor, do you understand</p> <p>16 prescribers to have any role in preventing the</p> <p>17 diversion of controlled substances?</p> <p>18 A. Insofar as we educate patients on</p> <p>19 keeping medications safely stored to prevent</p> <p>20 diversion, yes.</p> <p>21 Q. And what's the importance of safe</p> <p>22 storage of controlled substances?</p> <p>23 A. Well, we know that these</p> <p>24 medications are frequently misused and diverted</p> <p>25 by family members, and I have taught our</p>	<p>Page 55</p> <p>1 A. I don't recall.</p> <p>2 Q. But you don't understand</p> <p>3 pharmacists to be responsible for assessing the</p> <p>4 legitimate medical need of one of your</p> <p>5 patients, correct?</p> <p>6 MS. SCOLNICK: Object -- object to</p> <p>7 the form.</p> <p>8 A. I -- I understand the benefit of</p> <p>9 the clinical pharmacist and the practicing</p> <p>10 pharmacist's role in providing the medication</p> <p>11 to the patient. They often have information</p> <p>12 that is not available to me.</p> <p>13 Q. And what information might a</p> <p>14 pharmacist have that you don't see as a</p> <p>15 physician?</p> <p>16 A. They may see a patient's behavior</p> <p>17 at the pharmacy that seems suspicious. They</p> <p>18 may see a patient who has altered a</p> <p>19 prescription.</p> <p>20 Q. Are you -- have you become familiar</p> <p>21 with the role of wholesale pharmaceutical</p> <p>22 distributors in the controlled substance supply</p> <p>23 chain?</p> <p>24 A. No.</p> <p>25 Q. Have you become familiar with the</p>

<p style="text-align: right;">Page 58</p> <p>1 role of manufacturers in the controlled 2 substance supply chain? 3 A. Yes. I... 4 Q. And what's your understanding of 5 the manufacturers' role? 6 A. That they perform the research and 7 development of medications, they promote the 8 medications, and they manufacture the 9 medications. 10 Q. Are you aware that the DEA sets 11 production quotas for certain controlled 12 substances? 13 A. Yes. 14 Q. Including opioids? 15 A. Yes. 16 Q. Do you know what factors the DEA 17 considers in setting the quotas? 18 A. I do not. 19 Q. But you are aware that production 20 of opioids is limited to the quotas set by DEA, 21 correct? 22 A. Only very -- in very broad terms. 23 Q. And it's your understanding that a 24 person can't lawfully obtain a prescription 25 opioid without a legitimate prescription</p>	<p style="text-align: right;">Page 60</p> <p>1 A. Yes. 2 Q. And when -- when we say that a drug 3 is addictive, what does that mean? 4 A. Well, addiction starts as a 5 physical dependence. The body becomes 6 dependent on the medication. But the addiction 7 progresses when there are maladaptive behaviors 8 that accompany that physical and psychological 9 dependence on the opioid medication. 10 Q. And what do you mean by 11 "maladaptive behaviors"? 12 A. An excessive desire and craving to 13 obtain the drug, engaging in sometimes criminal 14 or other, I guess, unethical behavior to obtain 15 the drug. They're typically disregarding 16 family and friends and engaging in behavior 17 that is -- is not their norm. 18 Q. And in your experience, does 19 everyone who takes a prescription opioid 20 eventually become addicted to the drug? 21 A. No. 22 Q. And do you understand some 23 prescription opioids to be more addictive than 24 others? 25 A. Yes.</p>
<p style="text-align: right;">Page 59</p> <p>1 written by a licensed prescriber, correct? 2 A. Yes. 3 Q. And in addition to FDA-approved 4 prescription opioids, there -- you're also 5 aware of a number of illicit opioids, correct? 6 A. Yes. 7 Q. Including heroin? 8 A. Yes. 9 Q. Analgesics of fentanyl? 10 A. Yes. 11 Q. Carfentanil? 12 A. Yes. 13 Q. And you're aware that 14 manufacturers -- drug manufactures don't 15 manufacture those illicit opioids, right? 16 A. Yes. 17 Q. And wholesale distributors don't 18 distribute those, correct? 19 A. Yes. 20 Q. And they're not prescribed by 21 doctors like you, right? 22 A. That's correct. 23 Q. Before the break we talked a little 24 bit about opioids being addictive. Do you 25 recall that?</p>	<p style="text-align: right;">Page 61</p> <p>1 Q. Which are the more addictive, to 2 your knowledge? 3 A. The higher DEA classes, so C2 and 4 C1. 5 Q. Do you have a sense of how many 6 patients who are prescribed opioids by a doctor 7 eventually end up addicted to them? 8 A. I don't think that that's a known 9 factor. 10 Q. In your experience, have some 11 people -- strike that. 12 So in your experience, have you 13 come to see that some people are more likely to 14 become addicted to opioids than other people? 15 MS. SCOLNICK: Object to the form. 16 But you can answer. 17 A. Yes. 18 Q. And what are the factors that make 19 somebody more likely to become addicted? 20 A. Factors may include age, gender, 21 past history of substance use, family history 22 of substance abuse, and psychological disease. 23 Q. And as part of your decision about 24 whether to prescribe an opioid, do you consider 25 those factors in deciding whether the drug is</p>

<p style="text-align: right;">Page 62</p> <p>1 appropriate?</p> <p>2 A. I use those fact- -- factors to</p> <p>3 determine risk versus benefit.</p> <p>4 Q. So -- so it's always a balance,</p> <p>5 risk versus benefit, anytime you're deciding</p> <p>6 whether to write a prescription for opioids,</p> <p>7 correct?</p> <p>8 A. Correct.</p> <p>9 Q. So there might be a situation</p> <p>10 where -- so in your experience, has there been</p> <p>11 a situation where the factors indicate that the</p> <p>12 person might be likely to become addicted, but</p> <p>13 the benefit ultimately outweighs that risk?</p> <p>14 A. Yes.</p> <p>15 Q. And each decision you make about</p> <p>16 whether to write an opioid prescription, then,</p> <p>17 is based on your determination of the</p> <p>18 risk/benefits to the individual, specific</p> <p>19 patient in front of you, right?</p> <p>20 A. Yes.</p> <p>21 MS. SCOLNICK: Objection. That's</p> <p>22 been asked and answered.</p> <p>23 Q. And that patient-specific</p> <p>24 information that you consider, are you aware of</p> <p>25 that information being available to wholesale</p>	<p style="text-align: right;">Page 64</p> <p>1 Q. And you're better positioned than a</p> <p>2 wholesale pharmaceutical distributor?</p> <p>3 MS. SCOLNICK: Object as to form.</p> <p>4 A. Yes.</p> <p>5 Q. And a drug manufacturer?</p> <p>6 MS. SCOLNICK: Object as to form.</p> <p>7 A. Yes.</p> <p>8 Q. So as a practicing physician, do</p> <p>9 you keep up to date on relevant prescribing</p> <p>10 guidelines for prescription opioids?</p> <p>11 A. Yes, I do.</p> <p>12 Q. And sitting here today, which --</p> <p>13 what guidelines are you aware of relating to</p> <p>14 opioid prescribing that you have considered in</p> <p>15 your practice?</p> <p>16 A. I am aware of the 2016 CDC</p> <p>17 guidelines for safer opioid prescribing. I am</p> <p>18 aware of our state's guidelines for opioid</p> <p>19 prescribing. We also have state law, as well,</p> <p>20 that has recently been enacted, both for the</p> <p>21 setting of acute and chronic pain.</p> <p>22 Q. Since you joined MetroHealth in</p> <p>23 2007, has MetroHealth done anything to ensure</p> <p>24 that you, as a physician, keep up to date on</p> <p>25 the relevant prescribing guidelines for</p>
<p style="text-align: right;">Page 63</p> <p>1 pharmaceutical distributors?</p> <p>2 A. No.</p> <p>3 Q. What about drug manufacturers?</p> <p>4 A. No.</p> <p>5 Q. And because you have access to all</p> <p>6 of that patient-specific information, do you</p> <p>7 believe that you, as a treating physician, are</p> <p>8 best able to make that risk-benefit decision</p> <p>9 about whether to prescribe an opioid?</p> <p>10 MS. SCOLNICK: Object to the form.</p> <p>11 But you can answer.</p> <p>12 A. We make decisions based on the</p> <p>13 information that is available to us. And each</p> <p>14 individual decision is based on the current</p> <p>15 available literature, as well as evaluating</p> <p>16 those factors that we know to be risks for</p> <p>17 opioid misuse and harm.</p> <p>18 Q. But you believe that you, as a</p> <p>19 physician, are better positioned to make that</p> <p>20 risk-benefit analysis than, say, a third-party</p> <p>21 payer like an insurance company?</p> <p>22 MS. SCOLNICK: Object to the form.</p> <p>23 A. I -- I'm in a more proximate</p> <p>24 position, yes. I understand what's going on</p> <p>25 directly with the patient.</p>	<p style="text-align: right;">Page 65</p> <p>1 opioids?</p> <p>2 MS. SCOLNICK: Object. Beyond the</p> <p>3 scope.</p> <p>4 THE WITNESS: Do I answer?</p> <p>5 MS. SCOLNICK: Yes.</p> <p>6 A. Yes. Our Office of Opioid Safety</p> <p>7 has held town hall meetings for all of our</p> <p>8 providers. They're mandatory. We've also made</p> <p>9 available other online tools.</p> <p>10 Q. And the -- the mandatory town</p> <p>11 halls, did they start after the Office of</p> <p>12 Opioid Safety was launched?</p> <p>13 A. Yes, that's correct.</p> <p>14 Q. So that would be after July 2017?</p> <p>15 A. Yes, that's correct.</p> <p>16 Q. And before that, do you recall</p> <p>17 MetroHealth doing anything to make sure that</p> <p>18 you were aware of the relevant prescribing</p> <p>19 guidelines for opioids?</p> <p>20 MS. SCOLNICK: Beyond the scope.</p> <p>21 Objection.</p> <p>22 You can answer.</p> <p>23 THE WITNESS: Okay.</p> <p>24 A. We notified prescribers by e-mail</p> <p>25 of updates from the medical board. We held a</p>

<p style="text-align: right;">Page 66</p> <p>1 full-day conference on prescribing guidelines. 2 We held a full-day conference on the stigma of 3 opioid abuse, in which there was a panel on 4 policy.</p> <p>5 I updated the medical staff when 6 policy changes were made. We made an online 7 module mandatory for providing an update on all 8 state and -- I think it was only state law.</p> <p>9 Q. And do any of those efforts go -- 10 date all the way back to 2007 when you started?</p> <p>11 A. No.</p> <p>12 Q. When did they start?</p> <p>13 A. Of those --</p> <p>14 Q. Let me strike that --</p> <p>15 A. Yeah.</p> <p>16 Q. -- because that's a really broad 17 question.</p> <p>18 What's the earliest one you can 19 remember?</p> <p>20 A. I believe it was 2014 when we 21 updated our policy for the first time.</p> <p>22 Q. And is it fair to say that the 23 state guidelines for opioid prescribing have 24 changed considerably over the past 10 years?</p> <p>25 A. Prior to 2014, I'm -- I wasn't</p>	<p style="text-align: right;">Page 68</p> <p>1 reviewed it in detail. 2 Q. Haven't reviewed it in detail ever, 3 or just not recently? 4 A. Not recently. 5 Q. The bottom left-hand corner, 6 there's a date, June 22, 2011. Do you see 7 that? 8 A. Yes, I do. 9 Q. And do you recall reviewing these 10 documents around that time? 11 A. No. I -- I was not -- I did not 12 participate in creating this document or 13 reviewing it. 14 Q. Approximately when was the first 15 time you recall reviewing it? 16 A. I do not recall. 17 Q. Do you know who was responsible for 18 drafting these? 19 A. The chairman of emergency medicine. 20 Q. And is that Charles L. Emerman, 21 M.D., whose -- 22 A. Yes. 23 Q. -- name is in the lower right 24 corner? 25 A. Yes, that's correct.</p>
<p style="text-align: right;">Page 67</p> <p>1 aware. There may have been guidelines, but I 2 was not aware of them. But guidelines were 3 released around that time from the state 4 medical board, both for acute and chronic pain 5 management.</p> <p>6 Q. And -- and MetroHealth also issued 7 guidelines for chronic opioid management, 8 correct?</p> <p>9 A. We have a policy.</p> <p>10 - - - - -</p> <p>11 (Thereupon, Deposition Exhibit 2, 12 Document Titled "MHMC Guidelines for 13 Chronic Opioid Management," 14 MH000000027 to 000000036, was marked 15 for purposes of identification.)</p> <p>16 - - - - -</p> <p>17 Q. I'm going to hand you what I've 18 marked as Exhibit 2.</p> <p>19 Exhibit 2 is a document 20 Bates-labeled MH000000027. The title on the 21 top is "MHMC Guidelines for Chronic Opioid 22 Management."</p> <p>23 A. Yes.</p> <p>24 Q. Have you seen this document before?</p> <p>25 A. It looks familiar. I have not</p>	<p style="text-align: right;">Page 69</p> <p>1 Q. And he was the chief of emergency 2 medicine, you said?</p> <p>3 A. The chairman --</p> <p>4 Q. Chairman.</p> <p>5 A. -- of the department.</p> <p>6 Q. In the lower left-hand corner, 7 underneath the date, it says "Opioid Management 8 Task Force." Do you see that?</p> <p>9 A. Yes, I do.</p> <p>10 Q. What is the Opioid Management Task 11 Force?</p> <p>12 A. I'm not familiar with that task 13 force.</p> <p>14 Q. And you said that MetroHealth had a 15 policy for prescribing controlled substances?</p> <p>16 A. Correct.</p> <p>17 Q. Is this one of the policies you 18 were referring to?</p> <p>19 A. No.</p> <p>20 Q. Is this something different, in 21 your mind, from a policy?</p> <p>22 MS. SCOLNICK: Object to the form.</p> <p>23 But you can answer.</p> <p>24 A. Yes. A guideline sets best -- best 25 practice, typically based in evidence-based --</p>

<p style="text-align: right;">Page 70</p> <p>1 evidence, and a policy is a rule.</p> <p>2 Q. So realizing this is a gross</p> <p>3 simplification, but do you understand a</p> <p>4 guideline to be helpful but not mandatory, and</p> <p>5 a policy mandatory?</p> <p>6 A. Yes.</p> <p>7 Q. Okay. Do you know whether the</p> <p>8 Opioid Management Task Force still exists?</p> <p>9 A. It does not.</p> <p>10 Q. Do you know when it --</p> <p>11 A. Right. Let me -- let me clarify.</p> <p>12 I'm not familiar with this -- this task force.</p> <p>13 I believe that -- I -- I can't speak to that --</p> <p>14 that task force.</p> <p>15 Q. Got it.</p> <p>16 So about halfway down the first</p> <p>17 page of the document, the third full paragraph,</p> <p>18 it says, "The decision to initiate or continue</p> <p>19 chronic opioid management, like all decisions</p> <p>20 in medicine, must balance risk versus benefit."</p> <p>21 Do you see that?</p> <p>22 A. Yes.</p> <p>23 Q. And is that the type of</p> <p>24 risk-benefit analysis that we've been</p> <p>25 discussing today?</p>	<p style="text-align: right;">Page 72</p> <p>1 A. They are agreements between the</p> <p>2 patient and the provider that a provider will</p> <p>3 perform a duty to prescribe the medication, and</p> <p>4 the pa -- it outlines, essentially, both the</p> <p>5 physician's responsibilities and the patient's</p> <p>6 responsibilities.</p> <p>7 Q. And have you ever entered a</p> <p>8 narcotic management agreement with one of your</p> <p>9 patients?</p> <p>10 A. No.</p> <p>11 Q. Do you, as a result of your work at</p> <p>12 MetroHealth, have an understanding of when a</p> <p>13 narcotic management agreement is appropriate?</p> <p>14 A. Yes.</p> <p>15 Q. What's that understanding?</p> <p>16 A. Ongoing chronic opioid therapy.</p> <p>17 Q. And I take it because you work in</p> <p>18 the emergency room, you do not handle ongoing</p> <p>19 chronic opioid therapy?</p> <p>20 A. That's correct.</p> <p>21 Q. And so you said that the -- that</p> <p>22 Exhibit 2 did not influence your prescribing</p> <p>23 decisions. Why not?</p> <p>24 A. I don't prescribe medications for</p> <p>25 chronic opioid therap- -- I don't,</p>
<p style="text-align: right;">Page 71</p> <p>1 A. Yes.</p> <p>2 Q. Now, this particular document,</p> <p>3 Exhibit 2, has this document influenced your</p> <p>4 decisions about whether to prescribe opioids in</p> <p>5 terms of how to perform that risk-benefit</p> <p>6 analysis?</p> <p>7 MS. SCOLNICK: Objection.</p> <p>8 You can answer that.</p> <p>9 MS. McNAMARA: Yeah. Let me strike</p> <p>10 that. That's a terrible question. Don't start</p> <p>11 if you don't know where you're going to stop.</p> <p>12 Q. Has this -- in your practice did</p> <p>13 this particular document, Exhibit 2, influence</p> <p>14 at all your opioid prescribing?</p> <p>15 A. No.</p> <p>16 Q. Okay. On the fourth page of the</p> <p>17 document, the -- it has a number in the lower</p> <p>18 right-hand corner that ends with 30. It's a</p> <p>19 narcotic management agreement. Do you see</p> <p>20 that?</p> <p>21 A. Yes.</p> <p>22 Q. And are you familiar with narcotic</p> <p>23 management agreements?</p> <p>24 A. Yes.</p> <p>25 Q. What are they?</p>	<p style="text-align: right;">Page 73</p> <p>1 essentially, prescribe in this setting. I</p> <p>2 don't prescribe opioids for chronic pain</p> <p>3 management.</p> <p>4 Q. And this document relates to</p> <p>5 prescribing for chronic pain management?</p> <p>6 A. That's -- I think that's the title</p> <p>7 of it, "Guidelines for Chronic Opioid</p> <p>8 Management."</p> <p>9 - - - - -</p> <p>10 (Thereupon, Deposition Exhibit 3,</p> <p>11 2/1/2013 E-Mail from Vince Caraffi</p> <p>12 Re: Updates/Information From, with</p> <p>13 Attachment, CLEVE_000220806 to</p> <p>14 000220816, was marked for purposes</p> <p>15 of identification.)</p> <p>16 - - - - -</p> <p>17 Q. I'm going to hand you Exhibit 3.</p> <p>18 Exhibit 3 is a document that starts</p> <p>19 with Bates label CLEVE_000220806. And the</p> <p>20 cover document is an e-mail from Vince Caraffi</p> <p>21 to a number of different recipients, dated</p> <p>22 February 1, 2013.</p> <p>23 A. Uh-huh.</p> <p>24 Q. So you are one of the recipients --</p> <p>25 A. Yeah, I'm a recipient. I see that.</p>

<p style="text-align: right;">Page 74</p> <p>1 Q. -- of the -- of the cover e-mail. 2 But I am interested in the -- 3 A. The other -- 4 Q. -- the attachments, the first of 5 which is the "Ohio Emergency and Acute Care 6 Facility Opioids and Other Controlled 7 Substances (OOCS) Prescribing Guidelines." 8 Do you see that? 9 A. Yes. 10 Q. It rolls off the tongue. 11 A. It does. 12 Q. So in the lower left-hand corner, 13 it says, "Approved by GCOAT on April 18, 2012." 14 Do you see that? 15 A. Yes. 16 Q. And do you know what GCOAT is? 17 A. Yes. 18 Q. What is that? 19 A. The Governor's Cabinet Opioid 20 Action Team. 21 Q. And so these are guidelines that 22 relate to your specific area of practice, 23 correct? 24 A. Yes, that's correct. 25 Q. So when did you -- and -- and have</p>	<p style="text-align: right;">Page 76</p> <p>1 time, observe misuse and abuse of opioids that 2 were prescribed in the emergency department at 3 MetroHealth? 4 MS. SCOLNICK: Object to the form. 5 A. I see patients one time, typically. 6 And I could not speculate on the use of the 7 medications that I prescribed after the patient 8 left the emergency department. 9 Q. So do you have an understanding as 10 to why there was a growing concern about misuse 11 and abuse of opioids prescribed by emergency 12 departments? 13 A. Yes. 14 Q. What's that? 15 A. We saw an increased number of 16 fatalities from opioid overdose nationwide. 17 And I -- I think there was a concern that we 18 needed to look at all sources of opioid 19 medications. Opioid medications are commonly 20 prescribed from the emergency department 21 because the majority of patients who are seen 22 in the emergency department and treated have a 23 painful condition. 24 Q. And when you say they have a 25 painful condition, you're referring to a -- an</p>
<p style="text-align: right;">Page 75</p> <p>1 you seen this document before? 2 A. Yes. 3 Q. When was the first time you recall 4 seeing these guidelines? 5 A. Probably about the time that it was 6 released. 7 Q. And how did you become aware of 8 these guidelines at the time? 9 A. I don't recall, but probably 10 through the opiate task force. 11 Q. And Mr. Caraffi, who sent the 12 e-mail, is the chairman of the opiate task 13 force? 14 A. Yes. 15 Q. Were you aware of any guidelines 16 issued by the State before 2012 that related 17 specifically to emergency and acute care 18 facility opioid prescribing? 19 A. Not to my knowledge. 20 Q. Do you have an understanding as to 21 why these guidelines were issued in 2012? 22 A. I think there was a growing concern 23 of misuse and abuse of opioids prescribed in 24 the emergency department. 25 Q. And did you personally, at the</p>	<p style="text-align: right;">Page 77</p> <p>1 acute painful condition generally? Or could it 2 be chronic as well? 3 MS. SCOLNICK: Object to the form. 4 A. Patients can present with both 5 acute and chronic pain in the emergency 6 department. 7 Q. When you first read these 8 guidelines, did they influence in any way the 9 risk-benefit analysis that you undertake when 10 you're deciding whether or not to prescribe an 11 opioid? 12 A. Yes. I think this emphasized that 13 growing concern of the harms of opioid 14 medications. 15 Q. You testified earlier that 16 initially you weren't aware of the extent to 17 which opioids were addictive. 18 A. Right. 19 Q. Is that fair? 20 A. That's fair. 21 Q. And is -- is this particular 22 document, these guidelines, something that 23 helped change your understanding? 24 A. I think it did. I think there was 25 a -- a growing interest in learning more about</p>

<p style="text-align: right;">Page 78</p> <p>1 the addictiveness of opioid medications about 2 the time that these guidelines were released. 3 We also saw that MMWR report from 4 the CDC that declared an opioid prescription -- 5 prescription painkiller epidemic. And so I 6 think many physicians decided to start doing a 7 little bit more independent research and 8 evaluating the harms and -- and sort of doing a 9 reassessment of the harms versus the benefits.</p> <p>10 Q. So this is something that prompted 11 further inquiry?</p> <p>12 A. Correct.</p> <p>13 Q. Did these guidelines actually 14 change your prescribing practices with respect 15 to opioids at all?</p> <p>16 A. Yes.</p> <p>17 Q. How so?</p> <p>18 A. Can I spend a moment to review?</p> <p>19 Q. Take your time.</p> <p>20 A. Okay.</p> <p>21 (Telephonic interruption.)</p> <p>22 MS. McNAMARA: Can the people on 23 the line mute their phones, please?</p> <p>24 A. I would -- I would say that No. 7 25 was a change in my practice. We often</p>	<p style="text-align: right;">Page 80</p> <p>1 Q. With respect to No. 7, the 2 guideline for limiting prescriptions to a 3 three-day supply, you said that before this 4 guideline you would typically prescribe for 5 longer?</p> <p>6 A. I wouldn't say that I typically 7 prescribe. I would say that there were cases 8 in which I did prescribe longer than three 9 days.</p> <p>10 Q. And what was the benefit, in those 11 cases, of prescribing for longer?</p> <p>12 MS. SCOLNICK: Object to the form.</p> <p>13 A. My assessment of risk versus 14 benefit was related to a misunderstanding of 15 the potential harms with the medications when 16 taken for a longer duration of time.</p> <p>17 Q. And when you say misunderstanding 18 of the harms for a longer duration of time, 19 what are you referring -- what harms are you 20 referring to relating to the longer duration?</p> <p>21 A. Increased risk associated -- the 22 increased risk of addiction and dependency 23 associated with a longer duration of being on 24 the medication.</p> <p>25 Q. And do you understand that risk of</p>
<p style="text-align: right;">Page 79</p> <p>1 prescribed for longer than a three-day supply. 2 After this recommendation was created, I made a 3 concerted effort to reduce that to a three-day 4 supply.</p> <p>5 Q. And No. 7 says, just for the 6 record, "Except in rare circumstances, 7 prescriptions for OOCs should be limited to a 8 three-day supply. Most conditions seen in the 9 emergency/acute care facility should resolve or 10 improve within a few days. Continued pain 11 needs referral to the primary care physician or 12 appropriate specialist for reevaluation."</p> <p>13 Did I read that correctly?</p> <p>14 A. Yes.</p> <p>15 Q. And that's what you were referring 16 to?</p> <p>17 A. Yes.</p> <p>18 We also reevaluated our discharge 19 instructions and information that we provided 20 to patients after these guidelines were 21 prepared.</p> <p>22 At one point we had a guideline 23 similar to this posted on the wall in our 24 emergency department to inform patients of our 25 guidelines, which pertains to No. 8 and No. 9.</p>	<p style="text-align: right;">Page 81</p> <p>1 addiction and dependency to increase even if 2 the person takes the drug as you've prescribed 3 it?</p> <p>4 A. Yes.</p> <p>5 Q. Did anything in this document 6 itself change your understanding -- change your 7 underlying understanding of the addictiveness 8 of opioids?</p> <p>9 A. No. But as I stated before, it 10 prompted further inquiry.</p> <p>11 Q. And it -- did it prompt further 12 inquiry by you yourself?</p> <p>13 A. Yes.</p> <p>14 Q. What did you do?</p> <p>15 A. I researched addiction and sought 16 to learn more about the addictive nature of 17 medications.</p> <p>18 Q. So how did you -- how did you go 19 about doing that? Did you review the medical 20 literature?</p> <p>21 A. Yes.</p> <p>22 Q. And is there anything -- I know you 23 mentioned the 2012 CDC -- MWR?</p> <p>24 A. Yes.</p> <p>25 Q. Okay.</p>

<p style="text-align: right;">Page 82</p> <p>1 A. Morbidity and mortality report.</p> <p>2 Q. Was there anything -- anything else</p> <p>3 that you recall as helping to change your</p> <p>4 understanding of the addictiveness of opioids?</p> <p>5 A. I participated in the SCOPE of Pain</p> <p>6 prescribing course.</p> <p>7 Q. And when was that?</p> <p>8 A. I don't recall.</p> <p>9 Q. Was that around the 2012 time</p> <p>10 period or more recently?</p> <p>11 A. It's -- I don't recall.</p> <p>12 Q. And when you -- when you were</p> <p>13 researching addiction -- so I had asked about</p> <p>14 reviewing medical literature, and you mentioned</p> <p>15 the SCOPE of Pain course.</p> <p>16 Was there anything else that you</p> <p>17 did to learn more about the addictiveness of</p> <p>18 opioids?</p> <p>19 A. I reviewed medical literature. As</p> <p>20 to specifics, I can't -- I can't recall</p> <p>21 specific pieces of literature that I reviewed.</p> <p>22 Q. And then from that review you</p> <p>23 started to understand that opioids were more</p> <p>24 addictive than you initially understood?</p> <p>25 A. Correct.</p>	<p style="text-align: right;">Page 84</p> <p>1 A. Yes.</p> <p>2 Q. And that's been since 2012?</p> <p>3 A. Yes.</p> <p>4 Q. And do you understand your</p> <p>5 colleagues, like you, to always have been</p> <p>6 writing prescriptions based on their individual</p> <p>7 analysis of the risks and benefits of the</p> <p>8 medication?</p> <p>9 MS. SCOLNICK: Object to the form.</p> <p>10 But you can answer.</p> <p>11 A. I can't speak to my colleagues'</p> <p>12 decision-making in individual cases, but I -- I</p> <p>13 know and trust my colleagues, and their</p> <p>14 practice is typically an analysis of risk</p> <p>15 versus benefits just as -- as mine is.</p> <p>16 Q. And you have no reason to believe</p> <p>17 that your colleagues are writing illegitimate</p> <p>18 prescriptions for opioids, correct?</p> <p>19 MS. SCOLNICK: Object. Object as</p> <p>20 to form, and repetitive.</p> <p>21 A. None -- none that I am aware of.</p> <p>22 - - - - -</p> <p>23 (Thereupon, Deposition Exhibit 4,</p> <p>24 Document Titled "The MetroHealth</p> <p>25 System Policies Controlled Substance</p>
<p style="text-align: right;">Page 83</p> <p>1 Q. But prior to -- prior to that</p> <p>2 research and prior to developing more</p> <p>3 understanding about addictiveness, you believed</p> <p>4 that the prescriptions you were writing were</p> <p>5 based on your risk-benefit analysis of what was</p> <p>6 appropriate for the patient; is that right?</p> <p>7 A. That's correct.</p> <p>8 Q. Based on the information you had at</p> <p>9 the time?</p> <p>10 A. Based on the information that I had</p> <p>11 at the time, the prescriptions that I wrote, I</p> <p>12 believed that the benefit outweighed the risk.</p> <p>13 Q. To your knowledge, did your</p> <p>14 colleagues -- strike that, to back up for a</p> <p>15 second.</p> <p>16 So during the course of your work</p> <p>17 in the emergency room, have you been able to</p> <p>18 develop any sort of understanding of your</p> <p>19 colleagues' prescribing practices with respect</p> <p>20 to opioids?</p> <p>21 A. Yes.</p> <p>22 Q. And to your knowledge, have your</p> <p>23 colleagues also followed point No. 7 in the</p> <p>24 guidelines about limiting prescriptions to a</p> <p>25 three-day supply?</p>	<p style="text-align: right;">Page 85</p> <p>1 Prescribing Policy," MH000000272 to</p> <p>2 000000279, was marked for purposes</p> <p>3 of identification.)</p> <p>4 - - - - -</p> <p>5 Q. So I'm going to hand you Exhibit 4.</p> <p>6 Exhibit 4 is Bates-labeled MH000000272.</p> <p>7 So have you seen this document</p> <p>8 before?</p> <p>9 A. Yes, I have.</p> <p>10 Q. What is this document?</p> <p>11 A. This is our controlled medication</p> <p>12 safety committee, and pharmacy and therapeutic</p> <p>13 safety committee controlled substance</p> <p>14 prescribing policy.</p> <p>15 Q. So when you referred earlier to a</p> <p>16 MetroHealth policy, is this the document you</p> <p>17 were --</p> <p>18 A. This is the document.</p> <p>19 Q. And to kind of circle back to our</p> <p>20 discussion of guidelines versus policies, this</p> <p>21 document says it's a policy, correct?</p> <p>22 A. Yes.</p> <p>23 Q. So you understood this document --</p> <p>24 compliance with this document to be mandatory?</p> <p>25 A. That's correct.</p>

<p style="text-align: right;">Page 86</p> <p>1 Q. As opposed to Exhibit 3, the state 2 guidelines?</p> <p>3 A. Correct.</p> <p>4 Q. Which were not mandatory --</p> <p>5 A. Correct.</p> <p>6 Q. -- in your understanding, correct?</p> <p>7 A. That's correct.</p> <p>8 Q. So the date on this document in the 9 upper right-hand corner, it says, "Original 10 date, 9/20/15." Do you see that?</p> <p>11 A. Yes.</p> <p>12 Q. And when was the first time you 13 recall seeing this document?</p> <p>14 A. I participated in the drafting of 15 the language of this document.</p> <p>16 Q. In the upper right-hand corner, it 17 says Policy No. XIV, in Roman numerals, dash, 18 01. Do you see that?</p> <p>19 A. I do.</p> <p>20 Q. Is there a significance to the 21 "01"?</p> <p>22 MS. SCOLNICK: Object to the scope. 23 But you can answer it.</p> <p>24 A. I don't know.</p> <p>25 Q. Is this, to your knowledge, the</p>	<p style="text-align: right;">Page 88</p> <p>1 A. Dr. Sherrie Dixon Williams 2 participated, and I don't recall other members.</p> <p>3 Q. Do you recall approximately how 4 many people?</p> <p>5 A. No.</p> <p>6 Q. Do you know -- do you know why you 7 were enlisted to help work on this?</p> <p>8 A. At the time, Dr. Williams was 9 heading the opioid -- what -- what was our 10 opioid task force, our opioid safety task 11 force, at that time, and I had recently 12 participated in that committee.</p> <p>13 Q. And are you referring to the -- so 14 in -- strike that.</p> <p>15 In the upper left-hand corner, it 16 says, "Originated by opioid safety committee." 17 Do you see that?</p> <p>18 A. Yes, that's correct.</p> <p>19 Q. And is -- is that the opioid safety 20 task force you're referring to?</p> <p>21 A. It's the opioid safety committee 22 that was present at that time.</p> <p>23 Q. And what was that opioid -- what 24 was the -- what was the -- strike it.</p> <p>25 What was the purpose of that opioid</p>
<p style="text-align: right;">Page 87</p> <p>1 first MetroHealth controlled substance 2 prescribing policy?</p> <p>3 MS. SCOLNICK: Object to the scope. 4 But you can answer.</p> <p>5 A. Not that I'm aware of.</p> <p>6 Q. Meaning you're not aware of any 7 prior policies?</p> <p>8 A. Correct, I am not aware of prior 9 policies.</p> <p>10 Q. So you mentioned that you 11 participated in the drafting of the language in 12 this document, correct?</p> <p>13 A. Yes, that's correct.</p> <p>14 Q. Can you describe the process for 15 drafting this document?</p> <p>16 A. We engaged stakeholders from 17 throughout the hospital who practiced in a 18 variety of health care settings, and we 19 reviewed current policy, both state guidelines 20 as well as state law, and incorporated them 21 into this policy.</p> <p>22 Q. And was there a group of people who 23 worked on this?</p> <p>24 A. Yes.</p> <p>25 Q. Who was in that group?</p>	<p style="text-align: right;">Page 89</p> <p>1 safety committee at the time?</p> <p>2 MS. SCOLNICK: Object to the form.</p> <p>3 A. To improve opioid safety throughout 4 the hospital system.</p> <p>5 Q. When was it launched?</p> <p>6 A. I don't know.</p> <p>7 Q. Do you know what prompted it to be 8 created?</p> <p>9 A. I don't know.</p> <p>10 Q. When did you first become involved?</p> <p>11 A. Shortly before this policy was 12 created in 2015.</p> <p>13 Q. And you said Dr. Dixon Williams was 14 the head of that committee at the time?</p> <p>15 A. Yes, that's correct.</p> <p>16 Q. Aside from drafting this policy, 17 were there any specific initiatives that the 18 opioid safety committee was working on at the 19 time?</p> <p>20 A. I believe there was some 21 educational initiatives to increase awareness 22 of new state laws and -- and guidelines. I 23 don't recall specifics.</p> <p>24 Q. And were those educational 25 initiatives directed towards prescribers?</p>

<p style="text-align: right;">Page 90</p> <p>1 A. Yes.</p> <p>2 Q. Any educational initiatives related 3 to the addictiveness of opioids?</p> <p>4 A. I don't recall.</p> <p>5 Q. If you take a look at the second 6 page of the document under "General Procedures, 7 A" --</p> <p>8 A. Uh-huh.</p> <p>9 Q. -- it says, "All licensed 10 prescribers are required by law to register for 11 OARRS in accordance with Ohio state law."</p> <p>12 Do you see that?</p> <p>13 A. Yes.</p> <p>14 Q. What is OARRS?</p> <p>15 A. The Ohio Automated Rx Reporting 16 System.</p> <p>17 Q. And earlier you had mentioned PMP. 18 Do you recall that?</p> <p>19 A. Yes.</p> <p>20 Q. Were you referring to OARRS --</p> <p>21 A. Yes.</p> <p>22 Q. -- when --</p> <p>23 And OARRS is a database that 24 prescribers, among other people, are able to 25 query, correct?</p>	<p style="text-align: right;">Page 92</p> <p>1 compliant.</p> <p>2 Q. Were there any other reasons that 3 you drafted and issued this policy around 4 September 2015?</p> <p>5 A. There was a growing awareness 6 among -- I think nationwide that opioids were 7 becoming a crisis and leading to overdoses, and 8 this -- this became a growing concern among our 9 hospital leadership, and we wanted to take 10 initiative to do as much as we could to raise 11 awareness among our staff.</p> <p>12 Q. So you said it was a growing 13 concern in 2015?</p> <p>14 A. Yes.</p> <p>15 Q. But Cuyahoga County had had an 16 opiate task force for a number of years by that 17 point, correct?</p> <p>18 A. That's correct.</p> <p>19 Q. Since 2010, correct?</p> <p>20 A. I don't know the date that they 21 started. I was not a member until 2012.</p> <p>22 Q. But you know at least since 2012, 23 correct?</p> <p>24 A. I was aware in 2012, that's 25 correct.</p>
<p style="text-align: right;">Page 91</p> <p>1 A. That's correct.</p> <p>2 Q. And what information in -- in -- 3 strike that.</p> <p>4 And OARRS contains information 5 related to prescriptions -- controlled 6 substance prescriptions filled by an individual 7 patient, correct?</p> <p>8 A. Yes.</p> <p>9 Q. And it's now legally required to 10 check OARRS in certain circumstances, correct?</p> <p>11 A. Yes.</p> <p>12 Q. Has that always been the case, that 13 it was a legal requirement?</p> <p>14 A. No.</p> <p>15 Q. Do you know approximately the time 16 when it did become a legal requirement for 17 prescribers to check OARRS?</p> <p>18 A. I believe it was just prior to 19 2015, possibly 2014. I don't remember the 20 exact date.</p> <p>21 Q. And so was the -- was the creation 22 of a legal requirement to -- to check OARRS one 23 of the reasons for drafting this policy?</p> <p>24 A. We did want to raise awareness and 25 ensure that our -- our providers were</p>	<p style="text-align: right;">Page 93</p> <p>1 Q. And you yourself researched and 2 launched Project DAWN to combat the opioid 3 overdoses you were seeing in the emergency 4 room, correct?</p> <p>5 A. Yes, that's right. That happened 6 in 2013.</p> <p>7 Q. So why in 2015 was it still a 8 growing concern for you and your colleagues?</p> <p>9 MS. SCOLNICK: Objection to the 10 form.</p> <p>11 Q. Was it a full-blown concern by 12 then?</p> <p>13 A. I think the concern began even 14 earlier. It began in the beginning of the 15 2000s and the mid-1990s. It has continued to 16 grow over time. That wasn't a plateau. It 17 wasn't the beginning. It wasn't the end. It 18 was a growing concern.</p> <p>19 Q. Got it. So growing in terms of the 20 trajectory of it?</p> <p>21 A. Correct.</p> <p>22 Q. Okay. So the magnitude, not the 23 existence?</p> <p>24 A. Not the existence, but, yes, the 25 magnitude.</p>

<p style="text-align: right;">Page 94</p> <p>1 Q. Got it. 2 A. I think physicians also were 3 beginning to recognize some of the root causes 4 of -- of the epidemic as well. 5 Q. And what were those -- and by 6 "physicians," you -- you include yourself in 7 that group? 8 A. Yes. 9 Q. So what were the -- were the root 10 causes that you were beginning to identify? 11 A. An increased -- an increased 12 distribution of opioid prescrip- -- 13 prescriptions. There was a 600 percent 14 increase in the distribution of opioid grams in 15 the state of Ohio over about a decade. 16 Q. And when you say "increased 17 distribution," do you mean an increased number 18 of prescriptions being filled by pharmacies? 19 A. Yes, but -- but that would also 20 include medications personally furnished as 21 well. 22 Q. Personally furnished by 23 prescribers? 24 A. Prescribers, yes. 25 Q. So this increased distribution</p>	<p style="text-align: right;">Page 96</p> <p>1 requirement, did you regularly check OARRS as a 2 part of your practice before you wrote an 3 opioid prescription? 4 A. Yes. 5 Q. When did you start doing that? 6 A. As soon as I was aware that the 7 database was available. 8 Q. Do you know when the database was 9 created? 10 A. I think that I registered around 11 2008 or 2009, but I don't recall the precise 12 date. 13 Q. And what were the circumstances 14 under which you would check OARRS back in that 15 2008-2009 time frame? 16 MS. SCOLNICK: Object to the form. 17 You can answer. 18 A. I typically checked OARRS prior to 19 writing any prescription for -- for an opioid. 20 Q. Why did you do that? 21 A. We in the emergency department care 22 for a number of patients with substance use 23 disorders, and I was concerned that they may be 24 at risk for developing opioid use disorder or 25 may already have developed opioid use disorder.</p>
<p style="text-align: right;">Page 95</p> <p>1 reflected an increased number of prescriptions 2 that were being written, correct? 3 A. Prescriptions and medications that 4 were personally furnished, yes. 5 Q. And medica- -- medications that are 6 personally furnished by a prescriber, does that 7 prescriber still have to write a prescription 8 in order to personally furnish them? 9 A. That's not our practice at 10 MetroHealth. We don't personally furnish 11 opioid medications. 12 I believe at the time there were 13 some outside facilities that personally 14 furnished opioid medications directly to 15 patients. Our institution was not one of those 16 institutions. 17 Q. Do you currently -- strike that. 18 So turning back to -- to OARRS for 19 a second. 20 A. Uh-huh. 21 Q. So I take it you currently comply, 22 in your practice, with the legal requirements 23 for checking OARRS, correct? 24 A. Yes, that's correct. 25 Q. But back before it was a legal</p>	<p style="text-align: right;">Page 97</p> <p>1 Q. And did you continue that practice 2 of regularly checking OARRS up to 2015 when it 3 became mandatory? 4 A. Yes. 5 Q. And you continue to do that today? 6 A. Yes. 7 Q. From working in the emergency room, 8 have you developed an understanding of how 9 often your colleagues checked OARRS back in the 10 2008-2009 time frame when you first registered? 11 A. I'm sorry. Can you restate that 12 question? 13 Q. Yeah. So while working in the 14 emergency room in the period of time prior to 15 the legal requirements to check OARRS, did you 16 develop an understanding of how often your 17 colleagues were looking at OARRS? 18 A. I did. 19 Q. And how often would they do that? 20 A. I can't speak to the frequency, but 21 the majority of our providers in the emergency 22 department regularly checked OARRS. 23 Q. And that was the case even before 24 it was legally required? 25 A. I believe -- I believe that the</p>

<p style="text-align: right;">Page 98</p> <p>1 majority of providers in our department did, 2 although I can't speak to specific providers 3 and I can't speak outside of generalities. 4 Q. And to your knowledge, are your 5 colleagues in the emergency room complying with 6 the current requirements to check OARRS? 7 A. To my knowledge, yes. 8 Q. No reason to believe they are not 9 complying? 10 A. No. 11 MS. McNAMARA: What was that? 12 MS. SCOLNICK: I said it's been 13 about an hour, and I asked if she was getting 14 tired. 15 MS. McNAMARA: It's up to you. 16 THE WITNESS: I actually would like 17 to go to the bathroom if that's okay. 18 THE VIDEOGRAPHER: Off the record, 19 11:38. 20 (Luncheon recess.) 21 THE VIDEOGRAPHER: Back on the 22 record at 12:24 p.m. 23 BY MS. McNAMARA: 24 Q. Welcome back. 25 A. Thank you.</p>	<p style="text-align: right;">Page 100</p> <p>1 September 2015? 2 A. I don't know. It did end sometime 3 between 2015 and our opioid safety task force. 4 There was a gap. 5 Q. Earlier today you described the 6 policy as mandatory, correct? 7 A. Yes. 8 Q. Were you aware of MetroHealth 9 monitoring prescribers' compliance with the 10 policy in any way? 11 MS. SCOLNICK: Object. Beyond the 12 scope. 13 You can answer. 14 A. Can I take a moment to think about 15 that? I'm not sure that I -- I don't know. 16 I'm not aware of any monitoring that was 17 occurring in that immediate time frame. 18 Q. In the 2015 time frame? 19 A. In 2015. I was not in a leadership 20 role at that time. There may have been efforts 21 or whatnot that I was not participating in. 22 Q. Do you receive any performance 23 reviews as a staff physician at MetroHealth? 24 A. Yes. 25 Q. And as -- as part of your</p>
<p style="text-align: right;">Page 99</p> <p>1 Q. Before lunch we were discussing the 2 2015 controlled substance prescribing policy. 3 Do you recall that? 4 A. Yes. 5 Q. And that was drafted by the opioid 6 safety committee? 7 A. Yes, that's correct. 8 Q. Did you remain involved with the 9 opioid safety committee after the issuance of 10 the policy in September 2015? 11 MS. SCOLNICK: Objection to form. 12 A. Yes. 13 Q. And what did the opioid safety 14 committee do in terms of initiatives or 15 projects after the policy? 16 A. I -- I recall that we did a few 17 educational events. They also sponsored our 18 full-day conference on the stigma of opioid use 19 disorder. 20 Q. And for how long did that committee 21 exist after -- strike that. 22 Is that committee still in 23 existence today? 24 A. No. 25 Q. How long did it -- it exist after</p>	<p style="text-align: right;">Page 101</p> <p>1 performance review, the review process, was 2 compliance with the controlled substance 3 prescribing policy considered? 4 A. No. 5 Q. Do you know whether there was any 6 penalty for not complying with the controlled 7 substance prescribing policy? 8 A. Not to my knowledge. 9 Q. So over the past couple of years, 10 MetroHealth has undertaken a number of 11 initiatives to reduce opioid prescribing, 12 correct? 13 A. Yes. 14 Q. And when we're talking about 15 reducing opioid prescribing in terms of 16 MetroHealth's initiatives, is the focus on 17 reducing the number of prescriptions? 18 MS. SCOLNICK: Objection as to the 19 scope. She can answer. 20 A. We monitor a variety of metrics, 21 including the number of prescriptions. 22 Q. And do you also monitor the number 23 of pills? 24 A. Yes. 25 Q. And is this part of the work of the</p>

<p style="text-align: right;">Page 102</p> <p>1 opioid safety committee?</p> <p>2 A. No.</p> <p>3 Q. Who does the monitoring of the</p> <p>4 number of prescriptions and pills?</p> <p>5 A. That initiative was led by our</p> <p>6 opioid executive committee. Initial work was</p> <p>7 started in our controlled substance peer review</p> <p>8 committee, but that work accelerated when we</p> <p>9 formed the opioid executive committee.</p> <p>10 Q. So just so I get the committee</p> <p>11 names straight, so initial review by the</p> <p>12 controlled substances peer review committee?</p> <p>13 A. Yes.</p> <p>14 Q. And then it escalated to the opioid</p> <p>15 executive committee?</p> <p>16 A. They're separate committees.</p> <p>17 Q. Yes.</p> <p>18 A. The controlled substance peer</p> <p>19 review committee formed -- I don't want to --</p> <p>20 Q. Yeah.</p> <p>21 A. -- hold -- hold you to the date --</p> <p>22 Q. I will --</p> <p>23 A. -- be held to the date, but I think</p> <p>24 it was in 2016 that committee formed.</p> <p>25 And we did an analysis of</p>	<p style="text-align: right;">Page 104</p> <p>1 employed by MetroHealth?</p> <p>2 A. Yes.</p> <p>3 Q. Who is that person?</p> <p>4 A. Peter Lawson.</p> <p>5 Q. Who was responsible for deciding</p> <p>6 that MetroHealth should try to reduce the</p> <p>7 number of opioid prescriptions?</p> <p>8 MS. SCOLNICK: Object to the scope.</p> <p>9 A. I think that the work that we did</p> <p>10 with the controlled substance peer review</p> <p>11 committee sparked an interest in reducing the</p> <p>12 number of opioid prescriptions and other</p> <p>13 opioid-prescribing metrics, but it became</p> <p>14 formalized, and goals were set when leadership</p> <p>15 became involved.</p> <p>16 Q. And when you refer to leadership,</p> <p>17 who -- who are you referring to?</p> <p>18 A. Dr. Boulanger, the chief clinical</p> <p>19 officer at the hospital.</p> <p>20 Q. Now, this -- these strategies to</p> <p>21 reduce opioid prescribing, this is not a result</p> <p>22 of MetroHealth determining that its prescribers</p> <p>23 were writing illegitimate prescriptions --</p> <p>24 MS. SCOLNICK: Object as to --</p> <p>25 Q. -- right?</p>
<p style="text-align: right;">Page 103</p> <p>1 prescribing metrics, and we had a greater level</p> <p>2 of sophistication of our analysis when our</p> <p>3 opioid executive committee formed. That</p> <p>4 committee formed in 2- -- the end of 2017. We</p> <p>5 had an analy- -- analyst -- excuse me -- that</p> <p>6 was dedicated to obtaining that data for us.</p> <p>7 Q. And are you on the opioid executive</p> <p>8 committee?</p> <p>9 A. Yes.</p> <p>10 Q. How many members are on that</p> <p>11 committee?</p> <p>12 A. It varies. We have ad hoc members</p> <p>13 and regular members, but between 10 and 15.</p> <p>14 Q. And is that 10 to 15 total, ad hoc</p> <p>15 plus regular?</p> <p>16 A. I -- I couldn't --</p> <p>17 Q. Do you happen to know how many</p> <p>18 regular members there are?</p> <p>19 A. I don't know. May- -- maybe ten.</p> <p>20 Eight or -- maybe eight or ten.</p> <p>21 Q. And the -- the analyst that you</p> <p>22 mentioned with respect to the opioid executive</p> <p>23 committee, is that someone that was hired?</p> <p>24 A. No.</p> <p>25 Q. It was someone who was already</p>	<p style="text-align: right;">Page 105</p> <p>1 MS. SCOLNICK: Object as to form.</p> <p>2 A. No.</p> <p>3 Q. To your understanding, it's about</p> <p>4 the evolving knowledge of the addictiveness of</p> <p>5 these drugs, correct?</p> <p>6 A. And -- and the evolving knowledge</p> <p>7 of the adverse outcomes associated with them.</p> <p>8 So not just addictiveness, but also fatalities</p> <p>9 associated with them. And other associated</p> <p>10 morbidity, I should add.</p> <p>11 - - - - -</p> <p>12 (Thereupon, Deposition Exhibit 5,</p> <p>13 4/18/2017 The MetroHealth System</p> <p>14 Opioid Committee Meeting Minutes,</p> <p>15 MH000000566 to 000000567, was marked</p> <p>16 for purposes of identification.)</p> <p>17 - - - - -</p> <p>18 Q. Going to hand you Exhibit 5.</p> <p>19 A. Thank you.</p> <p>20 Q. Exhibit 5 is Bates-labeled</p> <p>21 MH000000566.</p> <p>22 Do you recognize this document?</p> <p>23 A. I do.</p> <p>24 Q. What is it?</p> <p>25 A. It is the minutes from our</p>

<p style="text-align: right;">Page 106</p> <p>1 controlled substance peer review committee. 2 Q. And this is the same committee that 3 was launched in 2016? 4 A. Yes. 5 Q. Okay. And the minutes indicate 6 that you were -- you were the chairperson? 7 A. Yes, that's correct. 8 I would add that at the top it says 9 "Opioid committee." This is -- this is peer 10 review. 11 Q. Okay. Does the peer review 12 committee meet regularly? 13 A. Yes. 14 Q. How often? 15 A. We try to meet monthly. Sometimes 16 meetings get canceled, but typically monthly. 17 Q. Have you been the chairperson since 18 the committee was started in 2016? 19 A. Yes. 20 Q. Do you have an understanding as to 21 why it was started? 22 A. We had a growing concern that 23 patients may be at risk for adverse outcomes 24 from opioid prescriptions. 25 Q. And what was the purpose of the</p>	<p style="text-align: right;">Page 108</p> <p>1 providers. We look at average MME. We also 2 look at opioid prescriptions co-prescribed with 3 a benzodiazepine. And there may be other 4 metrics I am not recalling, but those are the 5 main ones. 6 Q. And you mentioned "average MME." 7 What is "MME"? 8 A. Morphine milligram equivalent. 9 Q. And what's the significance of that 10 metric? 11 A. With increasing MME, there's an 12 increased risk of adverse events, including 13 overdose. 14 Q. And is it fair to say that the -- 15 the higher the MME, the stronger the dosage? 16 A. Yes. 17 Q. Just trying to -- 18 A. Yes. 19 Q. Fair, in layman's terms? 20 A. Yes. 21 Q. Okay. And you also mentioned 22 co-prescribing of opioids and benzodiazepine, 23 correct? 24 A. Yes, that's correct. 25 Q. So what's the significance of that</p>
<p style="text-align: right;">Page 107</p> <p>1 committee? What -- strike that. 2 The -- the committee still exists, 3 correct? 4 A. Yes. 5 Q. So what's the purpose of the 6 committee? 7 A. The committee serves to review 8 opioid-prescribing patterns to determine if 9 there are any outlying prescriber patterns, and 10 to reeducate providers if we identify providers 11 who may be prescribing in a manner that is -- 12 that varies from their peers or does not appear 13 to be consistent with guidelines. 14 Q. So does the committee -- does the 15 committee review the prescribing patterns of 16 all prescribers employed by MetroHealth? 17 A. We review prescribing data from all 18 prescribers. We don't do in-depth reviews of 19 all providers. 20 Q. Got it. 21 And what prescribing data does the 22 committee review? 23 A. We look at total prescriptions of 24 an opioid, a C2 prescription. We look at total 25 pills prescribed by that -- by pro-- by</p>	<p style="text-align: right;">Page 109</p> <p>1 metric? 2 A. It increases the risk for 3 respiratory depression and other adverse 4 events. 5 Q. And just what are some common 6 benzodiazepines? Just to -- for a background 7 in case we play this for the jury. 8 A. Sure. Valium, Ativan, Xanax. 9 Q. And so after you review the 10 prescribing data for everyone, do you select 11 certain providers for a more in-depth review? 12 A. Yes. 13 Q. And how -- how do you select those 14 providers? 15 A. We review providers who appear to 16 be prescribing at a higher rate on those 17 metrics compared to either their peers or 18 overall throughout the hospital. 19 Q. And when you say "peers," what are 20 you referring to? 21 A. We compare providers both to other 22 providers that are practicing in the same 23 practice environment, as well as overall, 24 compared to all providers within the hospital 25 system.</p>

<p style="text-align: right;">Page 110</p> <p>1 Q. So, for example, if someone 2 practices in the palliative care area, you 3 would compare them both to other palliative 4 care providers and then to other providers? 5 A. Yes, that's correct. It wouldn't 6 be fair to compare a palliative care physician 7 to a pediatrician. 8 Q. Because you'd expect a palliative 9 care provider, just because of the nature of 10 the practice, to prescribe more opioids? 11 A. Yes, that's correct. They have a 12 different patient population. 13 Q. So going to the minutes of this 14 particular meeting -- and actually back up. 15 Do you recall attending this 16 particular meeting? 17 A. Yes. 18 Q. In the lower left-hand corner, 19 there's a reference to the "pain board." Do 20 you see that? 21 A. Yes. 22 Q. What's the pain board? 23 A. This was a planned initiative to 24 create a group of physicians to review 25 complicated medical patients who are being</p>	<p style="text-align: right;">Page 112</p> <p>1 prescribers on safe opioid prescribing. I 2 think that's mentioned here in this minutes as 3 well. We also prioritized the simulation 4 program for safe -- safer prescribing. 5 Q. And what's a DEA waiver? 6 A. It is a waiver that allows a 7 prescriber to treat opioid use disorder with 8 opioid agonists. 9 For clarification, in this document 10 that training is referred to as MAT training, 11 medication-assisted treatment training. It can 12 be kind of used interchangeably, but "DEA 2000 13 waiver" is the correct terminology. 14 Q. Got it. 15 And the conference you're referring 16 to, is that the SCOPE of Pain discussed in this 17 document? 18 A. Yes, that's correct. 19 Q. And what was the simulation program 20 that you were describing? 21 A. It is an ongoing program that is 22 managed by our simulation center that involves 23 actors who act out a particular script 24 regarding opioid prescribing so that a 25 physician can walk into a room, have a</p>
<p style="text-align: right;">Page 111</p> <p>1 treated with opioids. This board did not form. 2 We never created this forum. 3 Q. And was it an internal MetroHealth 4 initiative? 5 A. It was an initiative of this -- it 6 was a -- it was a planned initiative for this 7 group that didn't get off the ground. 8 Q. Why didn't it get off the ground? 9 A. Other -- other initiative took 10 precedence. At that time I didn't have a -- a 11 staff. It was me running the show. 12 Q. Because this is in April 2017, 13 correct? 14 A. This is in April of 2017. 15 Q. So this is before the launch of the 16 Office of Opioid Safety? 17 A. It's before the launch of the 18 Office of Opioid Safety, and it was before we 19 were -- we received numerous grant funds that 20 required our immediate attention. 21 Q. So what initiatives did you 22 prioritize over the pain board at the time? 23 A. We prioritized initiatives to train 24 our physicians to obtain their DEA waiver. We 25 prioritized a conference to educate our</p>	<p style="text-align: right;">Page 113</p> <p>1 conversation with a patient about, you know, 2 one of a number of topics that we developed. 3 Prescribing opioids to a patient that they had 4 inherited on high doses of opioids was one of 5 the topics. Responding to a patient who had an 6 abnormal toxicology screen was another topic. 7 Q. And were you involved in selecting 8 the scenarios for the simulation? 9 A. I was not the lead on this project, 10 but I was involved. 11 Q. Was there a written script for 12 these? 13 A. Yes. 14 Q. Were you involved in the drafting 15 of the script? 16 A. Not involved in the drafting, but 17 involved in the review. 18 Q. And the simulation program did get 19 off the ground, correct? 20 A. Yes. 21 Q. When did that start? 22 A. I don't recall. Shortly after 23 this -- this meeting. 24 Q. And it's still going? 25 A. Yes.</p>

<p style="text-align: right;">Page 114</p> <p>1 Q. In the context of the pain board, 2 it references -- in the fourth line -- third 3 and fourth line, it says, "Dr. Margolias 4 discussed the draft algorithm from the opioid 5 advisory committee put together to create the 6 algorithm to put together the pieces to support 7 the algorithm."</p> <p>8 Do you see that?</p> <p>9 A. Your guess is as good as mine.</p> <p>10 Q. Do you know what algorithm they're 11 referring to?</p> <p>12 A. Again, this -- this project never 13 got off the ground. You know, we discussed 14 initiatives. We sort of do brainstorming. 15 At -- at this time there was no other opioid 16 group, so we were doing some brainstorming 17 about how we could develop a group or a forum 18 like this, but there -- there must have been 19 some algorithm that we were trying to -- trying 20 to sort out that never happened.</p> <p>21 Q. Got it.</p> <p>22 On the flip side of the document, 23 on page --</p> <p>24 A. Uh-huh.</p> <p>25 Q. -- 2, it discusses a review of a</p>	<p style="text-align: right;">Page 116</p> <p>1 A. I don't recall.</p> <p>2 Q. And so with a -- with a palliative 3 care provider, as I think we said before, you 4 expect a higher level of opioid prescribing 5 relative to other specialties like 6 pediatricians, correct?</p> <p>7 A. Correct.</p> <p>8 Q. So the fact that a palliative care 9 provider has a higher rate of opioid 10 prescribing than other specialties does not, in 11 and of itself, make that person an outlier, 12 right?</p> <p>13 A. Not necessarily.</p> <p>14 Q. So in the -- in the description of 15 the recommendation and action here, it says 16 that "There was a discussion of the severity of 17 illness of each patient." Do you see that?</p> <p>18 A. What line are you looking at?</p> <p>19 Q. Oh, I'm sorry. In the first full 20 paragraph, the second to the last line, it 21 says, "Severity of illness for each patient was 22 discussed."</p> <p>23 A. Yes.</p> <p>24 Q. Do you see that?</p> <p>25 A. Yes.</p>
<p style="text-align: right;">Page 115</p> <p>1 provider. Do you see that?</p> <p>2 A. I do.</p> <p>3 Q. And this particular provider is a 4 palliative care provider, correct?</p> <p>5 A. Yes, that's correct.</p> <p>6 Q. And it says that the provider was 7 reviewed by E. Horwath, correct?</p> <p>8 A. Yes.</p> <p>9 Q. Who is that?</p> <p>10 A. He's the chairman of psychiatry.</p> <p>11 Q. Okay. And when the committee looks 12 at the prescribing data and identifies specific 13 providers to look at more closely, about how 14 many providers do you identify at a time?</p> <p>15 A. We had different practices when we 16 first started our program. And we looked at 17 providers that had the highest metrics 18 initially. And we were somewhat limited 19 because intensive reviews are very lengthy and 20 physicians really didn't have the time allotted 21 to spend the several hours that it would take 22 to do a deep-dive review, so we prioritized the 23 providers who had the highest metrics.</p> <p>24 Q. And how many providers did you 25 identify in that initial cut?</p>	<p style="text-align: right;">Page 117</p> <p>1 Q. And is that typical of the review 2 process, that you look at each individual 3 patient?</p> <p>4 A. We look at the diagnosis associated 5 with the prescription.</p> <p>6 Q. Why is that important?</p> <p>7 A. To determine -- to -- basically to 8 put it in context, to put the prescription in 9 context.</p> <p>10 Q. Because some patients, depending on 11 their condition, might require higher amounts 12 of opioids to relieve their pain?</p> <p>13 A. It's specific to the patient, but 14 in general terms, yes.</p> <p>15 Q. And, for example, there's a -- the 16 next sentence in the review says, "Spinal cord 17 injury patient had the most prescribing."</p> <p>18 Do you see that?</p> <p>19 A. I do.</p> <p>20 Q. So that's an example of a person 21 who might need considerably more opioids than 22 the average patient?</p> <p>23 MS. SCOLNICK: Objection to the 24 form.</p> <p>25 A. Depends on the context. I don't</p>

<p style="text-align: right;">Page 118</p> <p>1 have the detailed information regarding that 2 patient's case. 3 Q. But some patients might 4 legitimately require high volumes of opioids, 5 fair? 6 MS. SCOLNICK: Objection to the 7 form. 8 A. Again, I would -- I would say that 9 it depends on the individual case of the 10 patient. And the time frame: acute versus 11 chronic. 12 Q. In terms of the review of the 13 individual diagnoses of the patients, is that 14 performed by a single physician? 15 A. No. 16 Q. How many people participate in that 17 review? 18 A. In this process that we had in 19 place at the time of these minutes, a provider 20 was chosen based on the metrics that we 21 reviewed, and then 10 patients were chosen, and 22 those patients were chosen based on the dosage, 23 or the MME, that they were prescribed. And 24 those individual patients were -- much more 25 intensive evaluation and review of those</p>	<p style="text-align: right;">Page 120</p> <p>1 Do you see that? 2 A. Yes. 3 Q. And is that -- is that the 4 conversation that you've just described? The 5 type of conversation? 6 A. Yes. That -- that resulted from 7 our peer review meeting discussing 8 Dr. Horwath's review of the 10 patients, and 9 the committee decided that based on his review 10 of those patients, that Dr. Horwath and I would 11 meet with the provider in question. 12 Q. You mentioned that one of -- one 13 part of the review is determining whether the 14 compliant -- whether the prescriber is 15 compliant with opioid stewardship measures? 16 A. Yes. 17 Q. What were you referring to by 18 "opioid stewardship measures"? 19 A. Were they complying with CDC 20 guidelines? Were they documenting that they 21 had queried OARRS and documenting a summary in 22 the medical record? 23 There were a number of other items 24 that are just not coming to my head right now. 25 Were they co-prescribing naloxone, was another</p>
<p style="text-align: right;">Page 119</p> <p>1 patients' medical charts was completed. 2 And the items that we reviewed 3 included the -- the diagnosis, the other 4 medical diagnoses that patient had, the other 5 medications that they were taking. And we 6 evaluated whether they were compliant with a 7 number of basic opioid stewardship measures. 8 We tried to determine based on the 9 chart review, but the next step was to meet 10 with the -- the provider and get additional 11 information, because sometimes we don't get the 12 full picture without having a conversation with 13 the doctor. 14 Q. Got it. 15 So if I'm understanding correctly, 16 the -- the review of the 10 patients was 17 conducted separately, and then there was a 18 conversation with the doctor -- 19 A. That's correct. 20 Q. -- to resolve any questions? 21 A. Right. 22 Q. And in the last paragraph in the 23 minutes, it says, "After a meaningful 24 discussion, Dr. Horwath and J. Papp will meet 25 with this provider after the next review."</p>	<p style="text-align: right;">Page 121</p> <p>1 one. But that's part of the CDC guidelines. 2 Q. And do you recall actually having a 3 subsequent meeting with this provider? 4 A. Yes. 5 Q. And what was the result of that 6 meeting? 7 A. I believe that's subject to peer 8 review confidentiality. 9 MS. SCOLNICK: Sorry. 10 Q. Let me ask that -- 11 MS. SCOLNICK: Yes, it is. 12 Q. Okay. So let me ask a more 13 targeted question. 14 Was -- was this provider 15 disciplined as a result of the review? 16 A. No. 17 Q. So is it -- 18 A. And I -- and I should clarify that 19 this is not a disciplinary committee. 20 Q. Yeah. 21 A. This is a peer review committee. 22 Q. So, yeah, my next -- is it fair to 23 say that the peer review process is intended 24 more to educate providers -- 25 A. Yes, that's correct.</p>

<p style="text-align: right;">Page 122</p> <p>1 Q. -- than to discipline them?</p> <p>2 A. Yes.</p> <p>3 Q. Okay. That makes sense.</p> <p>4 A number of the documents mention</p> <p>5 Epic. Are you --</p> <p>6 A. Yes.</p> <p>7 Q. -- familiar with Epic?</p> <p>8 A. Unfortunately, yes.</p> <p>9 Q. What is Epic?</p> <p>10 A. It's our electronic health record.</p> <p>11 Q. Is Epic an acronym for something?</p> <p>12 A. Not that I know of.</p> <p>13 Q. Okay.</p> <p>14 A. I don't think so.</p> <p>15 Q. How long has MetroHealth used Epic?</p> <p>16 A. As long as I've been at</p> <p>17 MetroHealth.</p> <p>18 Q. Since at least 2007?</p> <p>19 A. Since 2000. I trained at Metro as</p> <p>20 well. It's been there.</p> <p>21 Q. So I take it Epic has evolved over</p> <p>22 the years?</p> <p>23 A. It has. It's become more</p> <p>24 sophisticated.</p> <p>25 Q. Have there been any features added</p>	<p style="text-align: right;">Page 124</p> <p>1 Q. So if you turn ahead -- I don't</p> <p>2 think we have page numbers. There's a slide</p> <p>3 with the title "Provider Resources" at the top.</p> <p>4 I think it's the seventh page in.</p> <p>5 A. Oh, yes.</p> <p>6 Q. And the first item listed here is</p> <p>7 "Epic Support," correct?</p> <p>8 A. Yes.</p> <p>9 Q. And it lists an MME calculator,</p> <p>10 order sets/smart sets, best practice alerts,</p> <p>11 and links to resources and handouts, correct?</p> <p>12 A. Yes.</p> <p>13 Q. And are these some of the upgrades</p> <p>14 that the opioid executive committee implemented</p> <p>15 to Epic?</p> <p>16 A. These are examples of some of the</p> <p>17 resources that we created.</p> <p>18 Q. So what is an MME calculator?</p> <p>19 A. There are two forms of an MME</p> <p>20 calculator that we have created in Epic.</p> <p>21 And just for clarity, we have an</p> <p>22 informatics specialist who creates these for</p> <p>23 our Office of Opioid Safety. He actually is</p> <p>24 employed, not in our Office of Opioid Safety,</p> <p>25 but he's employed in the office of -- the</p>
<p style="text-align: right;">Page 123</p> <p>1 to Epic that relate specifically to opioid</p> <p>2 prescribing?</p> <p>3 A. Yes. Features that we added.</p> <p>4 Q. You, as in the Office of Opioid</p> <p>5 Safety?</p> <p>6 A. As in members of our opioid</p> <p>7 executive committee. I guess in our opioid</p> <p>8 safety committee as well, yeah.</p> <p>9 - - - - -</p> <p>10 (Thereupon, Deposition Exhibit 6,</p> <p>11 Slide Deck Titled, "Metro Health</p> <p>12 Office of Opioid Safety,"</p> <p>13 CUYAH_002048327, was marked for</p> <p>14 purposes of identification.)</p> <p>15 - - - - -</p> <p>16 Q. I'll hand you Exhibit 6. Exhibit 6</p> <p>17 is Bates-numbered CUYAH_002048327.</p> <p>18 Do you recognize this document?</p> <p>19 A. I do.</p> <p>20 Q. What is it?</p> <p>21 A. It is a PowerPoint presentation --</p> <p>22 I don't know the -- I don't know who the</p> <p>23 audience was -- that I put together to give an</p> <p>24 overview of the Office of Opioid Safety, our</p> <p>25 mission, and some of our goals.</p>	<p style="text-align: right;">Page 125</p> <p>1 informatics department. But his role is to</p> <p>2 create resources in Epic to make safer</p> <p>3 prescribing easier for providers.</p> <p>4 The MME calculator, again, it comes</p> <p>5 in two forms. We have a total MME calculator</p> <p>6 that puts the total MME of prescribed opioid</p> <p>7 medications in what we call the header in Epic,</p> <p>8 which is the top line of the screen that shows</p> <p>9 the patient's name, date of birth, medical</p> <p>10 record number, allergy and vital signs. And</p> <p>11 right next to that is total MME, and that's a</p> <p>12 calculation of all the opioid MMEs there are in</p> <p>13 Epic. That's one area where we have a</p> <p>14 calculator.</p> <p>15 I think since we built this -- or</p> <p>16 since I wrote this presentation, we've also</p> <p>17 created a second in-line calculator, so that</p> <p>18 when a prescriber is writing a prescription,</p> <p>19 before that prescriber signs the prescription,</p> <p>20 they can see what the total MME of that</p> <p>21 prescription is equal to.</p> <p>22 Q. And when did the total MME</p> <p>23 calculator in the header become available?</p> <p>24 A. 2017, I believe.</p> <p>25 Q. And the in-line calculator was --</p>

<p style="text-align: right;">Page 126</p> <p>1 A. It came much later. Either -- 2 either late 2017 or early 2018. I can't 3 remember.</p> <p>4 Q. It also references order sets and 5 smart sets. What are those?</p> <p>6 A. Order sets are standard -- it's 7 a -- sort of like a -- I guess the best way I 8 could describe it would be a list of common 9 orders that a physician may prescribe together.</p> <p>10 For instance, if I were admitting a 11 patient, I may want to order meals, activity 12 level, prescriptions, and an order set gives 13 you a list of options from which to choose 14 from. And there are standard defaults for 15 medications, including dosages, as well as 16 total pills dispensed.</p> <p>17 Q. So it -- it helps the physicians 18 decide on a dosage?</p> <p>19 A. It standardizes and simplifies the 20 ordering process.</p> <p>21 Q. And how does that help -- or, 22 scratch that.</p> <p>23 Does that help reduce opioid 24 prescribing?</p> <p>25 A. If done with that intent, it can</p>	<p style="text-align: right;">Page 128</p> <p>1 2017 as well, with that calculator and some of 2 the other things that we did.</p> <p>3 Q. Were there any adjustments made 4 after the issuance of -- after Ohio issued the 5 acute prescribing guidelines --</p> <p>6 A. Yes.</p> <p>7 Q. -- for opioids --</p> <p>8 A. Yes.</p> <p>9 Q. -- back in 2012?</p> <p>10 A. Oh, I --</p> <p>11 Q. Yes.</p> <p>12 A. I apologize. I thought -- I 13 thought you were referring to the acute pain 14 rules --</p> <p>15 Q. So let me -- let me back up --</p> <p>16 A. -- not the guidelines.</p> <p>17 Q. -- so we have a clear record.</p> <p>18 So do you recall, earlier, we 19 reviewed Ohio guidelines for opioid prescribing 20 in the acute care and emergency setting?</p> <p>21 A. Yes.</p> <p>22 Q. And one part of those guidelines 23 was that opioid prescriptions should not exceed 24 three days, correct?</p> <p>25 A. I don't think that's exactly --</p>
<p style="text-align: right;">Page 127</p> <p>1 reduce opioid prescribing.</p> <p>2 Q. What do you mean by "if done with 3 that intent"?</p> <p>4 A. Some of the specific initiatives 5 that we took were to reevaluate some of the 6 order sets and change the order sentence and 7 the default quantity prescribed.</p> <p>8 For instance, as an example, if we 9 saw a prescription for one tablet every four to 10 six hours with a 30-tablet default, that was 11 changed to one tablet every six hours with a 12 default option of three-, five-, or seven-day 13 supplies.</p> <p>14 Q. Got it.</p> <p>15 How long have there been order sets 16 in Epic?</p> <p>17 A. As long as I remember, which would 18 be since it started in, I guess, 2000.</p> <p>19 Q. But then there were recent 20 adjustments to the default sets for some 21 opioids?</p> <p>22 A. Yes, that's correct.</p> <p>23 Q. And when did that occur?</p> <p>24 A. Over the course of, boy, mostly in 25 2018. Probably some of that work happened in</p>	<p style="text-align: right;">Page 129</p> <p>1 Q. Okay.</p> <p>2 A. -- what those rules say, but --</p> <p>3 Q. Generally speaking it should be 4 limited to three days or less? You're welcome 5 to --</p> <p>6 A. We can -- we can --</p> <p>7 Q. Yeah, go for it.</p> <p>8 A. -- can -- just for the record 9 clarify exactly --</p> <p>10 Q. Sure.</p> <p>11 A. -- how it's worded.</p> <p>12 Q. Because I can't find mine.</p> <p>13 A. "Except in rare circumstances, 14 prescriptions should be limited to a three-day 15 supply."</p> <p>16 Q. Were any changes made to the order 17 sets after that guideline was issued?</p> <p>18 A. No.</p> <p>19 Q. Another of the provider resources 20 are best practice alerts.</p> <p>21 A. Yes.</p> <p>22 Q. What are those?</p> <p>23 A. Those are alerts to a provider when 24 an order is being placed to remind them of 25 current guidelines and other best practice.</p>

<p style="text-align: right;">Page 130</p> <p>1 Q. And so best practice alerts were 2 created for opioid prescriptions? 3 A. Yes. 4 Q. And what guidelines did they 5 reference or incorporate? 6 A. We included an alert for -- in an 7 ambulatory environment, we set an alert so that 8 if opioid prescribing exceeded 80 MME, that an 9 alert would fire, reminding the provider that 10 that was a high dose of a medication. 11 That same type of warning was also 12 set to fire in acute settings, but the 13 threshold was lower. It was set at 30 MME, and 14 that was to comply with state law. 15 Q. And in the -- in the ambula-- -- 16 strike that. 17 "Ambulatory environment," what 18 does -- what does that mean? 19 A. That means the outpatient setting. 20 Generally primary care, specialty clinics. 21 These are well patients who are 22 coming for a doctor visit, as opposed to acute 23 care where they're injured or having an acute 24 crisis. 25 Q. And the best practice -- the best</p>	<p style="text-align: right;">Page 132</p> <p>1 that? 2 A. Yes. 3 Q. And what type of resources and 4 handouts is Epic linked to for opioids? 5 A. We have links that when you -- it 6 would be nice if I could do a demo, but when 7 you click on the MME in the header, you get a 8 list of links. Those -- because when you click 9 on the MME in the header, first you get a 10 drill-down of how the prescriptions were 11 calculated to create that MME total that's in 12 the header, and then below that are a list of 13 links, sort of a resource guide that we created 14 to provide access to CDC guidelines, and on the 15 CDC website there's a number of handouts, so we 16 link to several of those. 17 Also link to state and other rules 18 and medical board rules there. We tried to put 19 all the kind of common resources the doctors 20 might want to have access to in one place. 21 Q. Underneath the Epic support and the 22 provider resources slide, it mentions pain 23 management boards. Do you see that? 24 A. I think I've lost my page. I'm 25 sorry. I should have numbered these.</p>
<p style="text-align: right;">Page 131</p> <p>1 practice alert in the ambulatory environment 2 for over 80 MME, when was that set? 3 A. That was set probably in 2017 or 4 2018. 5 Q. And was the acute warning for the 6 30 MME set around the same time? 7 A. Yes, I believe so. 8 Q. How long has Epic had the 9 capability of doing the best practice alerts? 10 A. I'm not an informatics specialist. 11 I can't answer that. 12 Q. Has -- so in -- in your practice, 13 have you received best practice alerts through 14 Epic when you've prescribed medications? 15 A. Yes. 16 Q. What's the earliest you can recall 17 receiving one? 18 A. I don't recall. Probably within 19 the last 10 years. 20 Q. But they definitely existed prior 21 to 2017-2018, when the specific alerts for 22 opioids -- 23 A. Yes. When we created those, yes. 24 Q. And the last provider resource is 25 the links to research and handouts. Do you see</p>	<p style="text-align: right;">Page 133</p> <p>1 Yeah, again, this was -- this was 2 one of our planned initiatives that just didn't 3 get off the ground. 4 Q. Got it. So the same pain board 5 we -- 6 A. The same thing, yeah. 7 Q. -- discussed earlier? Got it. 8 So if you flip ahead about three 9 slides, there's one with a heading "Predictive 10 Analytics." Do you see that? 11 A. Yes. 12 Q. And it says, "Use system data to 13 identify patients or providers who may benefit 14 from a specialized care pathway." 15 Did I read that correctly? 16 A. Yes. 17 Q. And what system data is this 18 referring to? 19 A. This is the prescribing data that 20 we reviewed with our analytic -- with our 21 analysts. 22 Q. And this prescribing data is 23 stored, I take it, in some sort of database at 24 MetroHealth? 25 MS. SCOLNICK: Object to the form.</p>

<p style="text-align: right;">Page 134</p> <p>1 A. It's stored in a secure file, in a 2 secured database, yes.</p> <p>3 Q. And MetroHealth has been compiling 4 and storing prescribing data for as long as you 5 worked there, correct?</p> <p>6 A. I --</p> <p>7 MS. SCOLNICK: Object to the scope.</p> <p>8 A. -- can't speak to any of the work 9 that MetroHealth did prior to my involvement.</p> <p>10 Q. So when did you first become aware 11 that MetroHealth had stored prescribing data 12 for the physicians it employs?</p> <p>13 A. I guess when we started our 14 controlled substance peer review committee. 15 That's when I requested the data.</p> <p>16 Q. And when you requested the data, 17 did you request data from -- did you request 18 prescribing data from previous years?</p> <p>19 A. Yes.</p> <p>20 Q. How far back did you request?</p> <p>21 A. I don't recall. Probably no more 22 than a year prior to our controlled substance 23 peer review committee formation.</p> <p>24 Q. Why not go back farther?</p> <p>25 A. Many physicians had changed their</p>	<p style="text-align: right;">Page 136</p> <p>1 A. The same data we -- we discussed 2 before. Total -- total opioid prescriptions, 3 total opioid prescriptions per encounter, total 4 opioid pills, average MME, opioids plus 5 benzodiazepines, and there may be some other 6 measures that I'm failing to recall.</p> <p>7 Q. And how far back did you look in 8 that analysis?</p> <p>9 MS. SCOLNICK: Objection.</p> <p>10 A. Our initial analysis?</p> <p>11 Q. Yes.</p> <p>12 A. Again, one year prior to the 13 formation of our committee is as far as back as 14 I recall that we looked.</p> <p>15 Q. I think -- my question was bad, and 16 I'm sorry.</p> <p>17 A. That's okay.</p> <p>18 Q. So you had said that many 19 physicians changed their practice, and you said 20 you understood that through a review of data 21 over time.</p> <p>22 A. Well, and we noticed that 23 prescribing patterns were changing, and that 24 was generally something that we expected would 25 have happened across the system, although we</p>
<p style="text-align: right;">Page 135</p> <p>1 practice, and it didn't seem pertinent to 2 re-educate providers who had clearly already 3 changed their practice.</p> <p>4 Q. And I know we spoke about your -- 5 your personal evolving understanding, but how 6 did you come to realize that many other 7 people -- many other physicians had also 8 changed their practice?</p> <p>9 MS. SCOLNICK: Object to the form.</p> <p>10 A. We reviewed data over time, and we 11 noticed a trend towards decreasing opioid 12 metrics on a number of the metrics that we 13 reviewed.</p> <p>14 Q. So the "we" is the controlled 15 substance peer review committee?</p> <p>16 A. That committee, as well as our 17 opioid executive committee. Again, when we 18 started our controlled substance peer review 19 committee, we had limited resources available 20 to us to analyze data. It became much more 21 sophisticated in later years.</p> <p>22 Q. So when you were reviewing data 23 over time, what specific data were you looking 24 at that you were just referring to?</p> <p>25 MS. SCOLNICK: Object to the form.</p>	<p style="text-align: right;">Page 137</p> <p>1 didn't -- may not have had any hard data to 2 prove that.</p> <p>3 And it generally doesn't make sense 4 to go too far back because, you know, 5 physicians' behavior and practice patterns 6 evolve over time with new information, and so 7 we thought it was pertinent to look one year 8 prior to the time of our committee formation.</p> <p>9 And we had limited resources at the 10 time as well. We didn't have an army of 11 physicians who were able to do these reviews. 12 So it's a very time-intensive process.</p> <p>13 Q. So have you ever looked at the 14 prescribing data back, say, to 2007 when you 15 started and analyzed that trend?</p> <p>16 MS. SCOLNICK: Objection. That has 17 been asked and answered.</p> <p>18 You can answer again.</p> <p>19 A. I'm not --</p> <p>20 Q. So separate and apart from the 21 analysis you just described, have you ever 22 looked at prescribing data going back farther 23 than a year, to say 2007, to get a -- a 24 longer-term trend?</p> <p>25 A. If there were an individual patient</p>

<p style="text-align: right;">Page 138</p> <p>1 who we were reviewing, we would do a detailed 2 chart review that may go back several years. 3 But we did not look system-wide or 4 provider-wide at -- at metrics, but we did go 5 back and look on individual patients several 6 years prior.</p> <p>7 Q. Got it. Okay.</p> <p>8 And if you flip forward another 9 four slides, there's a slide titled "Study and 10 Report Outcomes." Do you see that?</p> <p>11 A. I do.</p> <p>12 Q. And to put this in context, this 13 PowerPoint was written at the launch of the --</p> <p>14 A. Correct.</p> <p>15 Q. -- opioid safety committee, 16 correct?</p> <p>17 A. Correct. Right. It was -- right.</p> <p>18 Q. So these are -- are goals at the --</p> <p>19 A. These goals -- proposed.</p> <p>20 Q. -- start of the program?</p> <p>21 A. These were proposed outcomes that 22 we planned to look at. Some of them we looked 23 at. Some of them we did not. Sometimes we 24 found better measures that we felt were worthy 25 of looking at instead.</p>	<p style="text-align: right;">Page 140</p> <p>1 Q. What does that mean?</p> <p>2 A. We looked at not only total number 3 of pills, but total number of pills per patient 4 encounter. Because opioid prescribing is 5 not -- you know, different -- different 6 providers have -- see different volumes of 7 patients and have different numbers of 8 encounters that they participate in, and so a 9 rate is a better way to equalize that M --</p> <p>10 Q. So -- so it's basically a rate of 11 prescribing per patient seen?</p> <p>12 A. Correct.</p> <p>13 Q. Okay. And is that a metric you've 14 looked at?</p> <p>15 A. Yes.</p> <p>16 Q. And have you reduced the -- the 17 percentage of opioids per encounter?</p> <p>18 A. Again, system-wide we have reduced 19 that rate. There are individual providers who 20 have not reduced their rate.</p> <p>21 Q. And these individual providers who 22 haven't changed MMEs or reduced their rates, do 23 you, as the director of the Office of Opioid 24 Safety, consider that to be problematic?</p> <p>25 A. Yes.</p>
<p style="text-align: right;">Page 139</p> <p>1 Q. Have you looked at -- the first 2 item on the list is, "Reduce total average MME 3 throughout the system." Do you see that?</p> <p>4 A. Yes.</p> <p>5 Q. And is that a metric you've looked 6 at?</p> <p>7 A. Yes.</p> <p>8 Q. And have you reduced the total 9 average MME throughout the system since the 10 Office of Opioid Safety was launched?</p> <p>11 A. It depends on how you look at it. 12 So overall, I will say yes.</p> <p>13 Q. And why does it depend on how you 14 look at it?</p> <p>15 A. Because we have -- we look at data 16 system-wide, and we look at data based on each 17 department. System-wide, the MME has 18 decreased. Most departments have also 19 decreased the average MME. There are, however, 20 individual providers whose average MME have not 21 changed.</p> <p>22 Q. The second item on the list is, 23 "Reduce percentage of opioids per encounter." 24 Do you see that?</p> <p>25 A. Yes.</p>	<p style="text-align: right;">Page 141</p> <p>1 Q. Why?</p> <p>2 A. That indicates that they have not 3 responded to the education that we have 4 provided.</p> <p>5 Q. And are you -- so you've been able 6 to identify these people, I take it?</p> <p>7 A. We have a -- a few providers who 8 have not responded.</p> <p>9 Q. And are you taking any action or 10 directing any other initiatives toward those 11 specific providers?</p> <p>12 A. Yes.</p> <p>13 Q. What are you doing?</p> <p>14 A. We have provided additional 15 resources for them, including a second meeting, 16 to inform them of their progress or lack of 17 progress.</p> <p>18 We have required that they 19 participate in educational events. I -- 20 actually, I to want retract that. We have 21 recommended. We don't require. We have 22 recommended that they participate in 23 educational act- -- educational activities, and 24 we have offered to pay for those activities.</p> <p>25 We have also recently hired a pain</p>

<p style="text-align: right;">Page 142</p> <p>1 management pharmacist to work directly with 2 those providers to provide them additional 3 resources and support.</p> <p>4 Q. Does the Office of Opioid Safety 5 have the power to discipline physicians?</p> <p>6 A. No.</p> <p>7 Q. Notwithstanding their -- 8 notwithstanding the fact that they haven't 9 reduced their opioid prescribing, do you have 10 any reason to believe that these providers are 11 writing illegitimate prescriptions or not 12 performing a risk-benefit analysis --</p> <p>13 MS. SCOLNICK: Object to the form.</p> <p>14 Q. -- before prescribing an opioid?</p> <p>15 MS. SCOLNICK: Object to the form.</p> <p>16 A. No.</p> <p>17 Q. The next -- the next item on the 18 list is, "Improve OARRS documentation."</p> <p>19 A. Yes.</p> <p>20 Q. Have you looked at that?</p> <p>21 A. We have.</p> <p>22 Q. And has OARRS documentation 23 improved?</p> <p>24 A. We have a very limited measure of 25 evaluating OARRS documentation. Many providers</p>	<p style="text-align: right;">Page 144</p> <p>1 run is a report on the use of the "dot OARRS" 2 phrase.</p> <p>3 Q. Okay. So you can see how many 4 times that was run per opioid prescription -- 5 over the number of opioid prescriptions?</p> <p>6 A. We can associate -- we can 7 associate that with the times that an opioid 8 prescription was written during the same 9 encounter. And so it's a rough estimate of 10 compliance, simply because checking OARRS is 11 not required with every prescription, and so a 12 provider may be in compliance with the law and 13 have written the prescription, but our report 14 wouldn't give us that detailed information.</p> <p>15 Q. And what's -- what's the rough 16 estimate?</p> <p>17 A. System-wide?</p> <p>18 Q. Yes.</p> <p>19 A. I don't recall off the top of my 20 head.</p> <p>21 Q. System-wide, have you looked at 22 whether there's been a decrease of prescribing 23 of opioids plus benzodiazepines?</p> <p>24 A. There -- it has remained relatively 25 stable. But it's a very, very small percentage</p>
<p style="text-align: right;">Page 143</p> <p>1 write in their own documentation that they've 2 checked OARRS. We created a smart phrase that 3 we can query and run reports on, but compliance 4 is difficult. And many providers choose to 5 write in their documentation of OARRS, and so 6 we have a very rough estimate of their 7 compliance with OARRS.</p> <p>8 You may know that the pharmacy 9 board does not allow us to measure compliance 10 of our providers. We have no -- no way to get 11 a report on who is checking OARRS. So we rely 12 on the documentation. But that has improved.</p> <p>13 Q. Okay. So this is providers' 14 self-documentation of checking OARRS?</p> <p>15 A. Yes, providing a summary of what 16 was seen in the OARRS database.</p> <p>17 Q. And based on the information you 18 have, what's the percentage of times 19 pharmacists check OARRS?</p> <p>20 A. Times pharmacists check OARRS?</p> <p>21 Q. Actually, strike that.</p> <p>22 So what is the -- what is the 23 metric that you maintain with respect to OARRS 24 documentation?</p> <p>25 A. The only report that we are able to</p>	<p style="text-align: right;">Page 145</p> <p>1 of opioid prescriptions that are written with a 2 benzodiazepine to begin with, so it's very hard 3 to make movement in that metric, and we can 4 only query when an opioid is prescribed at the 5 same time as the benzo prescription.</p> <p>6 Q. The next item is a "Decrease of 7 opioid refills within visits of less than six 8 months." Do you see that?</p> <p>9 A. I do.</p> <p>10 Q. Is that something you've looked at?</p> <p>11 A. Oh, I -- it was worded strangely.</p> <p>12 So I don't think we run any reports 13 on this, but generally when we review a 14 provider, we want to see that that provider is 15 having a face-to-face encounter with the 16 patient at least every -- now we look at it 17 every three months. We expect providers to see 18 a patient, who is on chronic opioid therapies 19 at least, face-to-face at minimum every three 20 months; ideally, more frequently.</p> <p>21 Q. Have you looked at the next item on 22 the list, "Compliance with education/REMS"?</p> <p>23 A. Yes, we have looked at that.</p> <p>24 Q. What is REMS?</p> <p>25 A. Risk evaluation and mitigation</p>

<p style="text-align: right;">Page 146</p> <p>1 strategy.</p> <p>2 Q. And has compliance with education</p> <p>3 and REMS increased since the Office of Opioid</p> <p>4 Safety was launched?</p> <p>5 A. Yes.</p> <p>6 Q. And what information are you</p> <p>7 looking at to draw that conclusion?</p> <p>8 A. So we have performed, you know,</p> <p>9 over 100 opioid safety town halls for providers</p> <p>10 throughout the system, and we measure</p> <p>11 compliance.</p> <p>12 For REMS we only require this to be</p> <p>13 completed for providers who -- and again, I</p> <p>14 should back up and say we never require this</p> <p>15 for our providers; however, we recommend that</p> <p>16 providers participate in the REMS activity if</p> <p>17 they prescribe long-acting, controlled-release</p> <p>18 substances, but we -- we don't require it.</p> <p>19 The only means that I have of</p> <p>20 ensuring compliance is with providers who we</p> <p>21 have offered to pay for their course, or if</p> <p>22 they attended our SCOPE of Pain course that was</p> <p>23 live.</p> <p>24 Q. And that's what you're looking at</p> <p>25 when you say compliance with education --</p>	<p style="text-align: right;">Page 148</p> <p>1 been?</p> <p>2 A. What specifically are you --</p> <p>3 Q. Have you had -- has there been a</p> <p>4 reduction in the number of opioid-related</p> <p>5 deaths?</p> <p>6 A. I can't answer that.</p> <p>7 Q. In general or attributable to</p> <p>8 efforts by your team at MetroHealth?</p> <p>9 A. I -- I don't have an answer to that</p> <p>10 question.</p> <p>11 Q. Got it. Okay.</p> <p>12 Have there been -- strike that.</p> <p>13 - - - - -</p> <p>14 (Thereupon, Deposition Exhibit 7,</p> <p>15 Document Titled, "Safer Opioid</p> <p>16 Prescribing for Healthcare</p> <p>17 Providers," MH000000131 to</p> <p>18 000000157, was marked for purposes</p> <p>19 of identification.)</p> <p>20 - - - - -</p> <p>21 Q. I'll hand you Exhibit 7.</p> <p>22 A. Thank you.</p> <p>23 Q. This has a Bates label MH000000131.</p> <p>24 MS. HOSMER: Could you repeat that</p> <p>25 Bates, please?</p>
<p style="text-align: right;">Page 147</p> <p>1 A. Yes.</p> <p>2 Q. -- has increased?</p> <p>3 A. Yes.</p> <p>4 Q. The next item is, "Increase total</p> <p>5 MAT providers"?</p> <p>6 A. Yes.</p> <p>7 Q. Have you looked at that?</p> <p>8 A. Yes.</p> <p>9 Q. And has the number of MAT providers</p> <p>10 increased?</p> <p>11 A. Yes.</p> <p>12 Q. And the last metric is, "Reduce</p> <p>13 opioid-related deaths." Do you see that?</p> <p>14 A. I do.</p> <p>15 Q. And I assume that's something you</p> <p>16 have looked at?</p> <p>17 A. We've looked at countywide data.</p> <p>18 It's difficult to tie those back to MetroHealth</p> <p>19 patients, but.</p> <p>20 Q. So have you looked at MetroHealth</p> <p>21 specifically?</p> <p>22 A. We have attempted to identify</p> <p>23 overall opioid deaths that had an encounter at</p> <p>24 MetroHealth, yes.</p> <p>25 Q. And what has the result of that</p>	<p style="text-align: right;">Page 149</p> <p>1 MS. McNAMARA: Oh, sure.</p> <p>2 MH000000131.</p> <p>3 MS. HOSMER: Thank you.</p> <p>4 Q. Have you seen this document before?</p> <p>5 A. Yes, I have.</p> <p>6 Q. And this is a PowerPoint titled</p> <p>7 "Safer Opioid Prescribing for Health Care</p> <p>8 Providers" --</p> <p>9 A. Right.</p> <p>10 Q. -- correct?</p> <p>11 Did you draft this PowerPoint?</p> <p>12 A. Yes.</p> <p>13 Q. And do you recall the date or a</p> <p>14 general time frame of this?</p> <p>15 A. When it was drafted?</p> <p>16 Q. Yes.</p> <p>17 A. The end of 2017. It may have been</p> <p>18 updated. This looks like an updated version</p> <p>19 that occurred in 2018.</p> <p>20 Q. And what was the purpose of this</p> <p>21 PowerPoint?</p> <p>22 A. This was the opioid safety town</p> <p>23 hall that was delivered to providers throughout</p> <p>24 the MetroHealth system that was mandatory.</p> <p>25 Q. And I think you mentioned having</p>

<p style="text-align: right;">Page 150</p> <p>1 held a hundred town halls or so?</p> <p>2 A. Somewhere in -- somewhere in that 3 neighborhood.</p> <p>4 Q. And at each of them you would have 5 given a presentation like --</p> <p>6 A. Yes.</p> <p>7 Q. -- Exhibit --</p> <p>8 A. Seven.</p> <p>9 Q. -- 7? Yes.</p> <p>10 A. Yes.</p> <p>11 Q. Okay. I want to look at the slide 12 with the Bates number in the lower right corner 13 ending in 134.</p> <p>14 A. Okay.</p> <p>15 Q. It says, "Why is safe opioid 16 prescribing important?" Do you see that?</p> <p>17 A. Yes.</p> <p>18 Q. And at the top it says, on the 19 left, "Patient safety," and then on the right, 20 next to a bullet point, "Unsafe prescribing is 21 driving the opioid crisis."</p> <p>22 Do you see that?</p> <p>23 A. Yes.</p> <p>24 Q. And is that something you wrote?</p> <p>25 A. Yes.</p>	<p style="text-align: right;">Page 152</p> <p>1 prescription opioid was present?</p> <p>2 A. I don't believe that that was 3 specified in those articles.</p> <p>4 Q. So you're not sure one way or the 5 other?</p> <p>6 A. I don't know, no.</p> <p>7 Q. And then I'd like to look at the 8 slide with the Bates number ending in 136, 9 which has a "Heroin Risk Continuum." Do you 10 see that?</p> <p>11 A. Yes.</p> <p>12 Q. And did you create this "Heroin 13 Risk Continuum"?</p> <p>14 A. I did not.</p> <p>15 Q. Where did you get it?</p> <p>16 A. These two slides were borrowed from 17 the medical examiner's presentation. I believe 18 Hugh Shannon was the creator of this -- these 19 two slides.</p> <p>20 Q. From the Cuyahoga County Medical 21 Examiner's Office?</p> <p>22 A. Yeah. Yeah, it says, "Source: 23 Cuyahoga County Medical Examiner's Office."</p> <p>24 Q. Okay. So the -- the "Heroin Risk 25 Continuum" at the top of the page kind of</p>
<p style="text-align: right;">Page 151</p> <p>1 Q. What did you mean by that?</p> <p>2 A. I meant that prescribing that was 3 not compliant with current CDC guidelines.</p> <p>4 Q. So not prescriptions that were not 5 written for a legitimate medical purpose; just 6 prescriptions that did not comply with the 7 current guidelines?</p> <p>8 MS. SCOLNICK: Object to the form.</p> <p>9 A. In this context, it refers to 10 prescriptions that were not compliant with CDC 11 guidelines.</p> <p>12 Q. And underneath that is a second 13 bullet point that says, "37 percent of overdose 14 deaths from prescribed opioids annually."</p> <p>15 Do you see that?</p> <p>16 A. I do.</p> <p>17 Q. And when it says "from prescribed 18 opioids" -- "overdose deaths from prescribed 19 opioids," was is that figure referring to? 37 20 percent of what?</p> <p>21 A. My references are listed at the 22 bottom. I don't recall which source -- which 23 of those sources I used to obtain that number.</p> <p>24 Q. Do you know whether that 37 percent 25 figure refers to overdose deaths where only a</p>	<p style="text-align: right;">Page 153</p> <p>1 contains a schematic where on the right we have 2 a person not using heroin, then there's an auto 3 accident, and then there's a previous legal 4 prescription for opioids. Do you see that?</p> <p>5 A. I do.</p> <p>6 Q. And then the next step on the 7 continuum is using heroin. Do you see that?</p> <p>8 A. Yes.</p> <p>9 Q. But in your experience, not 10 everyone who receives a legitimate legal -- or 11 strike it.</p> <p>12 In your experience, not everyone 13 who receives a legal prescription for opioids 14 after being in an auto accident goes on to use 15 heroin, correct?</p> <p>16 MS. SCOLNICK: Object -- object to 17 the form.</p> <p>18 A. No, not everybody.</p> <p>19 Q. And is it fair to say that in your 20 experience -- strike that. Strike that.</p> <p>21 So is it fair to say that in your 22 experience most of the people who go from a 23 previous legal prescription for opioids to 24 using heroin had first abused prescription 25 opioids in some way --</p>

<p style="text-align: right;">Page 154</p> <p>1 MS. SCOLNICK: Object to the form. 2 Q. -- as opposed to using them only as 3 prescribed? 4 A. Based on medical literature that 5 I've reviewed, the number varies between about 6 75 and 80 percent of individuals reported a 7 previous opioid that was prescribed prior to 8 starting heroin. 9 Q. But that 75 to 80 percent figure, 10 does that look at a -- the temporal link 11 between the opioid prescription and the heroin? 12 MS. SCOLNICK: Object as to form. 13 A. I'm not -- I don't believe that 14 that was studied in the papers that I've 15 reviewed. 16 Q. So that 75 to 80 percent figure 17 could include somebody who got a legitimate 18 prescription for opioids in 2013, started using 19 heroin in 2018, correct? 20 MS. SCOLNICK: Object -- object as 21 to form. 22 A. I would have to do additional 23 review of medical literature to give you an 24 accurate answer. 25 Q. But in your exper- -- but I think</p>	<p style="text-align: right;">Page 156</p> <p>1 misuse or abuse their medications before -- 2 misuse or abuse opioid medications before 3 transitioning to heroin? 4 MS. SCOLNICK: Object as to form. 5 A. I have -- I've cited to two studies 6 here. One of them looks at patients who are 7 being treated for chronic pain, and the outcome 8 that they reported is stated here, that 9 approximately 50 percent of those patients were 10 found to misuse or abuse those medications. 11 The second article that I cited 12 here looked at patients who are entering 13 treatment for heroin addiction, and those 14 patients reported -- actually I think the 15 number is 75 percent entering treatment for 16 heroin addiction reported that their first 17 opioid use was an opioid medication -- a 18 prescription opioid medication. 19 I can't extrapolate the findings of 20 those studies. Those are the findings that 21 they reported. 22 Q. Got it. Okay. 23 I -- I was wondering if you had 24 read anything different. Anything outside of 25 those two studies that you're describing.</p>
<p style="text-align: right;">Page 155</p> <p>1 my -- my question, I think, was a little bit 2 different, because I asked in your experience 3 and based on your reading of the literature, is 4 it fair to say that most of the people who go 5 from a legal prescription to heroin first abuse 6 the prescription by taking it other than as 7 medically directed, by diverting it, or some 8 other means? 9 MS. SCOLNICK: Object to the form 10 and also the scope. 11 A. I don't know that I can answer that 12 question. 13 Q. If you flip ahead to 140, it says 14 at the top of the slide "Prescription Opioid 15 Abuse and Heroin." Do you see that? 16 A. Yes. 17 Q. And in the left-hand column, it 18 says, "Up to 50 percent of patients using 19 chronic opioid therapy for non-cancer pain 20 abuse or misuse" -- "misuse or abuse their 21 medications." Do you see that? 22 A. Yes. 23 Q. And have you ever looked at, 24 reviewed any literature relating to how many 25 patients -- relating to how many patients first</p>	<p style="text-align: right;">Page 157</p> <p>1 A. I have looked at other articles, 2 yes. 3 Q. That look at the link between 4 abusing prescription opioids and transitioning 5 to heroin? 6 A. Not that I recall. 7 Q. Okay. In your experience, do you 8 have a sense of -- have you developed a sense 9 of how likely it is a person will become 10 addicted to a prescription opioid if they take 11 it exactly as the doctor prescribes it for the 12 duration of time in which it was prescribed? 13 MS. SCOLNICK: Object as to form. 14 A. I don't think that anybody has an 15 answer to that. There are clear risk factors 16 that place a person at higher risk that we've 17 discussed previously, but there's -- there's no 18 clear answer to which patients and exactly, 19 precisely what that risk is. Nobody knows the 20 answer to that. 21 Q. When you're treating someone in the 22 emergency room for an overdose, do you ever 23 determine whether that person was misusing 24 prescription opioids leading up to the 25 overdose?</p>

<p style="text-align: right;">Page 158</p> <p>1 MS. SCOLNICK: Object as to form.</p> <p>2 A. Yes. We've had patients report to</p> <p>3 us that they misused the medications.</p> <p>4 Q. Other than self-reporting, is there</p> <p>5 any way you could determine whether someone was</p> <p>6 abusing prescription -- whether an overdose</p> <p>7 patient had been abusing prescription opioids?</p> <p>8 A. We would take into consideration a</p> <p>9 number of factors: the route of</p> <p>10 administration; if -- if we obtained any lab</p> <p>11 testing, that may give us some additional</p> <p>12 information; review of the OARRS report may</p> <p>13 give us information about polypharmacy. We</p> <p>14 look at all of those factors.</p> <p>15 But that only tells us what the</p> <p>16 patient is taking. It doesn't necessarily tell</p> <p>17 us what the patient knows or what their</p> <p>18 perceived risk was. Sometimes they just don't</p> <p>19 know that taking medications together can be</p> <p>20 dangerous.</p> <p>21 Q. And when you say that, you're</p> <p>22 talking about prescription medications?</p> <p>23 A. Well, not necessarily. Drinking</p> <p>24 alcohol, using sleeping pills, sedating</p> <p>25 psychiatric medications can all contribute to</p>	<p style="text-align: right;">Page 160</p> <p>1 open to MetroHealth inpatients?</p> <p>2 A. I believe that's how it operates.</p> <p>3 Q. Do you know whether the retail</p> <p>4 pharmacy is open to the public?</p> <p>5 A. Yes, it is.</p> <p>6 Q. Do you know approximately what</p> <p>7 percentage of prescriptions at the retail</p> <p>8 pharmacy are filled by MetroHealth patients?</p> <p>9 MS. SCOLNICK: I'm going to object</p> <p>10 to beyond the scope. She can answer it.</p> <p>11 A. I don't know the answer to that</p> <p>12 question.</p> <p>13 Q. Do you know or have a sense of what</p> <p>14 percentage of the prescriptions you write are</p> <p>15 filled at the MetroHealth pharmacy?</p> <p>16 A. I do not know.</p> <p>17 Q. Do you recall a -- strike that.</p> <p>18 Have you ever written an opioid</p> <p>19 prescription that was filled at MetroHealth</p> <p>20 pharmacy?</p> <p>21 A. Again, I don't have any information</p> <p>22 about where prescriptions are filled. But</p> <p>23 having worked there for almost 18 years, I</p> <p>24 assume that some of those prescriptions were</p> <p>25 filled at our retail pharmacy.</p>
<p style="text-align: right;">Page 159</p> <p>1 the CNS and respiratory depression when taken</p> <p>2 with an opioid, and sometimes the patients just</p> <p>3 don't know.</p> <p>4 Q. Okay.</p> <p>5 MS. McNAMARA: I don't know how</p> <p>6 long we've been going, but I'm about to switch</p> <p>7 to a new topic.</p> <p>8 THE WITNESS: This would be a nice</p> <p>9 time for a break for me.</p> <p>10 MS. McNAMARA: Okay. Perfect.</p> <p>11 THE VIDEOGRAPHER: Off the record</p> <p>12 at 1:50 p.m.</p> <p>13 (A recess was taken.)</p> <p>14 THE VIDEOGRAPHER: Back on the</p> <p>15 record at 2:05 p.m.</p> <p>16 BY MS. McNAMARA:</p> <p>17 Q. Welcome back.</p> <p>18 A. Thank you.</p> <p>19 Q. Dr. Papp, are you aware that</p> <p>20 MetroHealth has a pharmacy?</p> <p>21 A. Yes, I am.</p> <p>22 Q. And is that a retail pharmacy?</p> <p>23 A. We have both an inpatient and a</p> <p>24 retail pharmacy.</p> <p>25 Q. And is the inpatient pharmacy only</p>	<p style="text-align: right;">Page 161</p> <p>1 Q. Has the MetroHealth pharmacy ever</p> <p>2 called you with questions about an opioid</p> <p>3 prescription you wrote?</p> <p>4 A. I don't recall.</p> <p>5 Q. Have you ever heard of MetroHealth</p> <p>6 pharmacy calling a colleague with questions</p> <p>7 about an opioid prescription?</p> <p>8 A. We have received calls from the</p> <p>9 pharmacists in the past regarding prescriptions</p> <p>10 written in the emergency department.</p> <p>11 Q. And are you aware of MetroHealth</p> <p>12 pharmacy ever refusing to fill an opioid</p> <p>13 prescription written by someone in the</p> <p>14 emergency department?</p> <p>15 A. Not to my knowledge.</p> <p>16 Q. Based on your experience, do you</p> <p>17 have any reason to believe that anyone working</p> <p>18 at the MetroHealth pharmacy was diverting</p> <p>19 controlled substances for uses other than</p> <p>20 filling prescriptions written by licensed</p> <p>21 prescribers?</p> <p>22 MS. SCOLNICK: Objection based on</p> <p>23 scope.</p> <p>24 A. And I don't have any direct</p> <p>25 knowledge of the staffing of the pharmacy.</p>

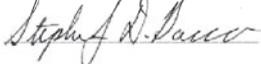
<p style="text-align: right;">Page 162</p> <p>1 Q. So before this morning when I 2 introduced myself, have you ever heard of 3 Cardinal Health?</p> <p>4 A. Yes.</p> <p>5 Q. In what context?</p> <p>6 A. I believe they're one of the 7 distributors for our hospital.</p> <p>8 Q. They sell medications to 9 MetroHealth pharmacy?</p> <p>10 A. I'm not completely sure of the 11 scope of the service that they provide to 12 MetroHealth, but I know that we have a 13 relationship with Cardinal Health.</p> <p>14 Q. Have you personally in the course 15 of your work ever had any with dealings with 16 anybody from Cardinal Health?</p> <p>17 A. Yes.</p> <p>18 Q. Who was that?</p> <p>19 A. I don't remember names, but I did 20 receive a \$35,000 education grant from Cardinal 21 Health to educate providers on safer opioid 22 prescribing in the emergency department.</p> <p>23 Q. And when did you receive that 24 grant?</p> <p>25 A. 2017, I believe.</p>	<p style="text-align: right;">Page 164</p> <p>1 distributor that is affiliated with our 2 hospital.</p> <p>3 Q. And have -- have you personally had 4 any dealings with anybody from AmerisourceBergen?</p> <p>5 A. Not that I recall.</p> <p>6 Q. Have you heard of H.D. Smith?</p> <p>7 A. No.</p> <p>8 Q. What about ANDA, A-N-D-A?</p> <p>9 A. No.</p> <p>10 Q. Miami-Luken?</p> <p>11 A. No.</p> <p>12 Q. Prescription Supply, Inc.?</p> <p>13 A. No.</p> <p>14 MS. McNAMARA: I think that's all I 15 have. Thank you very much for your time. I 16 appreciate it.</p> <p>17 THE WITNESS: Thank you.</p> <p>18 MR. DAVISON: Could we go off the 19 record for a minute?</p> <p>20 THE VIDEOGRAPHER: Off the record 21 at 2:11 p.m.</p> <p>22 (A recess was taken.)</p> <p>23 THE VIDEOGRAPHER: Back on the 24 record at 2:12 p.m.</p> <p>25 EXAMINATION OF JOAN PAPP, M.D.</p>
<p style="text-align: right;">Page 163</p> <p>1 Q. Was that around the -- was that in 2 connection with the launch of the office for 3 opioid safety?</p> <p>4 A. It was in that time frame, yes.</p> <p>5 Q. So in the summer of 2017 time 6 frame?</p> <p>7 A. About that time. That sounds 8 right.</p> <p>9 Q. Any other interactions with 10 Cardinal Health?</p> <p>11 A. Not that I can recall.</p> <p>12 Q. Have you ever heard of McKesson 13 Corporation?</p> <p>14 A. I've heard the name, yes.</p> <p>15 Q. And in what context have you heard 16 of McKesson?</p> <p>17 A. I believe they're a manufacturer.</p> <p>18 Q. Have you ever had any professional 19 interactions with anybody from McKesson?</p> <p>20 A. Not that I can recall.</p> <p>21 Q. Have you ever heard of 22 AmerisourceBergen Drug Corporation?</p> <p>23 A. Yes.</p> <p>24 Q. In what context?</p> <p>25 A. I believe they're also a</p>	<p style="text-align: right;">Page 165</p> <p>1 BY MR. DAVISON:</p> <p>2 Q. Dr. Papp, thank you for your time 3 so far today. We will try and keep this brief 4 to get you out of here.</p> <p>5 As I mentioned, my name is William 6 Davison. I'm from the law firm of Ropes & 7 Gray, and I represent Mallinckrodt 8 Pharmaceuticals, which is one of the 9 manufacturers that's a defendant in this 10 litigation.</p> <p>11 So we talked a lot earlier about 12 prescription opioids, pretty much all day. You 13 still prescribe prescription opioids to 14 appropriate patients today; is that correct?</p> <p>15 A. I prescribe opioids based on the 16 risks and the benefits to patients, yes.</p> <p>17 Q. Okay. And what are the benefits of 18 prescription opiates?</p> <p>19 A. Reduction in pain.</p> <p>20 Q. And are there particular benefits 21 to using an opioid versus, say, some other type 22 of prescription pain medication?</p> <p>23 A. It really is very patient and 24 condition specific. Some patients have 25 allergies to non-opioid medications. There are</p>

<p style="text-align: right;">Page 166</p> <p>1 other specific conditions in which an opioid is 2 a better choice than a non-opioid medication. 3 Q. And so for -- for each prescription 4 that you may write of -- of an opioid, you 5 would weigh the benefits you've discussed with 6 the risks of that particular class of 7 medications. Is that fair? 8 A. Yes. 9 MS. SCOLNICK: Object to the form. 10 A. Yes. 11 Q. Okay. So I want to discuss briefly 12 the information you rely upon in weighing the 13 risks and the benefits in making that 14 determination. 15 Do you rely on the FDA-approved 16 label in evaluating the risks of prescription 17 opioids? 18 A. Yes, I do. 19 Q. Okay. Do you rely on your med 20 school education in weighing the risks and the 21 benefits of prescription opioids? 22 MS. SCOLNICK: Object to the form. 23 A. Yes. However, that education has 24 evolved since medical school. 25 Q. Fair enough. Do you also rely on</p>	<p style="text-align: right;">Page 168</p> <p>1 provide us additional information. So I -- I 2 would say that there may be, based on the 3 individual patient. 4 Q. Can you think of any other 5 information that you would rely upon that you 6 would listen to instead of, say, the FDA 7 warning label? 8 MS. SCOLNICK: Object to the -- to 9 the form, and I didn't hear it. 10 MR. DAVISON: Oh, I apologize. 11 Q. Can you think of any other sources 12 of information that you would rely on instead 13 of the FDA warning label? 14 MS. SCOLNICK: Object as to form. 15 A. I think it's a synthesis of all of 16 these sources together that help to make a -- 17 to help us to weigh those benefits. 18 Q. Okay. And those were all of the 19 sources we just discussed; is that correct? 20 A. Correct. 21 Q. And as of right now, you can't 22 think -- 23 A. And -- 24 Q. -- of any -- I'm sorry. 25 A. And potentially some other</p>
<p style="text-align: right;">Page 167</p> <p>1 your experience over time in weighing the risks 2 and benefits of opioid medications? 3 A. My continuing education, yes. 4 Q. Okay. Do you rely upon scientific 5 literature in weighing the risks and benefits 6 of opioid medications? 7 A. Yes. 8 Q. Do you rely upon government 9 guidance? 10 A. Yes. 11 Q. Do you rely upon specific 12 conversations with the patient in question 13 relating to particular risk factors? 14 A. Yes. 15 Q. Do you rely upon looking at the 16 OARRS database for additional information? 17 A. Yes. 18 Q. Are there any other information 19 that you rely upon in determining and weighing 20 the risks and benefits of prescribing 21 prescription opioids? 22 A. There may be other factors. 23 Occasionally, we get additional information 24 from family members or other sources like EMS 25 that brings a patient in. They may be able to</p>	<p style="text-align: right;">Page 169</p> <p>1 sources -- 2 Q. Okay. 3 A. -- that I can't re- - can't think 4 of right now. 5 Q. Okay. Moving to a different area, 6 are you familiar with the distinction between 7 generic and branded prescription medication? 8 A. Yes. 9 Q. Okay. And do you write generic 10 prescriptions? 11 A. Yes. 12 Q. And have you written branded 13 prescriptions in the past? 14 A. Yes. 15 Q. Okay. And when you write a generic 16 description [sic] is that for a particular 17 manufacturer's product? 18 A. No. 19 Q. Going -- we talked earlier -- and I 20 apologize for jumping around. I'm just trying 21 to move quickly for you here. 22 We talked about the peer review 23 board a little bit ago, and I just wanted to 24 make clear, simply because a prescriber was 25 evaluated by the peer review board, that does</p>

<p style="text-align: right;">Page 170</p> <p>1 not mean he had written a prescription that was 2 not medically necessary. Is that fair? 3 A. That is correct. 4 Q. And even if it was suggested that 5 that prescriber be retrained, that does not 6 mean that he had written a prescription that 7 was not medically necessary, correct? 8 MS. SCOLNICK: Object as to the 9 form.</p> <p>10 A. And I would restate that. 11 Q. Uh-huh. 12 A. State that we provide additional 13 support and resources to those providers rather 14 than stating that we re- -- we don't retrain -- 15 Q. Fair enough. 16 A. -- providers. 17 Q. Let me -- let me restate it, 18 then -- 19 A. Okay. 20 Q. -- with that. 21 Simply because the peer review 22 board provided additional support and resources 23 to a provider does not mean that that provider 24 had written a prescription that was not 25 medically necessary, correct?</p>	<p style="text-align: right;">Page 172</p> <p>1 from Zukerman Spaeder here on behalf of CVS 2 Indiana, LLC, and CVS Rx Services, 3 Incorporated. I introduced myself a while ago, 4 but nice to meet you again. I just have a few 5 questions for you. 6 You un- -- first off, you 7 understand that the rules that Colleen gave you 8 at the beginning of the deposition still apply 9 now? 10 A. Yes. 11 Q. And that you're still under oath? 12 A. Yes. 13 Q. Okay. And if you don't understand 14 a question that I ask, just let me know and 15 I'll try to improve upon it. 16 A. Got it. 17 Q. Okay. Before I introduced myself 18 today, were you aware that CVS Indiana, LLC, 19 was a Defendant in this case? 20 A. No, I was not. 21 Q. Were you aware that CVS Rx 22 Services, Incorporated, was a Defendant in this 23 case? 24 A. No. 25 Q. Were you aware that Rite Aid of</p>
<p style="text-align: right;">Page 171</p> <p>1 MS. SCOLNICK: Object as to form. 2 A. That does not mean that that 3 prescription was not medically indicated. 4 Q. And are you personally aware of any 5 opioid prescription written by a MetroHealth 6 prescriber that was not medically necessary? 7 MS. SCOLNICK: Object as to form. 8 A. I -- I don't know that I can 9 accurately answer that question. We evaluate 10 the prescriptions that come to our attention 11 based on evaluation of specific patients and 12 review of their medical records, but I've not 13 been aware of any prescriptions that are 14 illegitimate or inappropriate. 15 Q. Okay. 16 MR. DAVISON: That's -- that's all 17 I have. We can go off the record. 18 THE VIDEOGRAPHER: Off the record 19 at 2:18 p.m. 20 (A recess was taken.) 21 THE VIDEOGRAPHER: Back on the 22 record at 2:20 p.m. 23 EXAMINATION OF JOAN PAPP, M.D. 24 BY MR. HERMAN: 25 Q. Hi, Dr. Papp. I'm Steve Herman</p>	<p style="text-align: right;">Page 173</p> <p>1 Maryland is a Defendant in this case? 2 A. No. 3 Q. Were you aware that Walgreens is a 4 Defendant in this case? 5 A. No. 6 Q. Were you aware that Walmart is a 7 Defendant in this case? 8 A. No. 9 Q. Do you have any personal knowledge 10 of why CVS Indiana, LLC, was named as a 11 Defendant in this case? 12 A. I do not. 13 Q. Do you have any personal knowledge 14 of why CVS Rx Services, Incorporated, was named 15 as a Defendant in this case? 16 A. I do not. 17 Q. Do you have any personal knowledge 18 of why Walmart was named as a Defendant in this 19 case? 20 A. No. 21 Q. Do you have any personal knowledge 22 of why Rite Aid was named as a Defendant in 23 this case? 24 A. No. 25 Q. Do you have any personal knowledge</p>

<p style="text-align: right;">Page 174</p> <p>1 of why Walgreens was named as a Defendant in 2 this case?</p> <p>3 A. No.</p> <p>4 Q. Are you personally aware of any 5 facts that would support any claims against CVS 6 Indiana, LLC?</p> <p>7 MS. SCOLNICK: Object as to form.</p> <p>8 A. No.</p> <p>9 Q. Are you personally aware of any 10 facts that would support claims against CVS Rx 11 Services, Incorporated?</p> <p>12 MS. SCOLNICK: The same objection.</p> <p>13 A. I have no knowledge to support or 14 refute.</p> <p>15 Q. Okay. Do you have any knowledge to 16 support or refute any of the claims against 17 Walmart?</p> <p>18 A. No.</p> <p>19 Q. Rite Aid of Maryland?</p> <p>20 A. No.</p> <p>21 Q. Walgreens?</p> <p>22 A. No.</p> <p>23 Q. Are you personally aware of any 24 conduct by CVS, Rite Aid, Walgreens, Walmart, 25 or Walgreens [sic] that caused harm to Cuyahoga</p>	<p style="text-align: right;">Page 176</p> <p>1 Q. Okay. And are you aware that CVS, 2 Rite Aid, Walgreens, and Walmart are named in 3 this litigation as distributors and not as 4 retail pharmacies?</p> <p>5 A. Only the information that you've 6 provided to me here today.</p> <p>7 Q. Okay. Dr. Papp, are you aware of 8 how many opioid pills MetroHealth prescribed in 9 2018?</p> <p>10 MS. SCOLNICK: Object as to scope.</p> <p>11 A. I don't have those numbers in front 12 of me.</p> <p>13 Q. Are you aware that MetroHealth 14 prescribed millions of pills -- MetroHealth 15 provi- -- prescribers prescribed millions of 16 opioid pills in 2018?</p> <p>17 A. Again, I -- I know -- I can't give 18 you a precise number, but I -- I am aware that 19 millions of pills have been prescribed.</p> <p>20 Q. And MetroHealth prescribers have 21 pre- -- prescribed millions of pills each year 22 from 2010 all the way through 2018?</p> <p>23 A. Yes.</p> <p>24 Q. Are you aware of that?</p> <p>25 A. Yes.</p>
<p style="text-align: right;">Page 175</p> <p>1 County?</p> <p>2 A. Not to my knowledge.</p> <p>3 Q. Okay. Have you had any 4 communications with CVS regarding prescription 5 opioids?</p> <p>6 A. It's likely. I can't remember any 7 specific instances, though.</p> <p>8 Q. Okay. And were those 9 communications just about filling 10 prescriptions?</p> <p>11 A. Often we get calls from retail 12 pharmacies regarding prescriptions.</p> <p>13 Q. Okay. So --</p> <p>14 A. And I'm -- I'm confident that at 15 some point in my career I've received a call 16 from CVS.</p> <p>17 Q. But same question with regard to 18 Wal- -- or Rite Aid?</p> <p>19 A. I probably received calls from all 20 local retail pharmacists --</p> <p>21 Q. Okay.</p> <p>22 A. -- at one point or another.</p> <p>23 Q. Okay. But you don't recall any of 24 those specific conversations?</p> <p>25 A. Not any specific conversations.</p>	<p style="text-align: right;">Page 177</p> <p>1 Q. Okay. And just by looking at those 2 number of pills, you can't tell whether any of 3 those prescriptions for prescription opioids 4 were medically appropriate?</p> <p>5 MS. SCOLNICK: Object as to form.</p> <p>6 A. Not without a detailed review.</p> <p>7 Q. That's right. You'd need to do a 8 detailed review of each individual 9 prescription?</p> <p>10 A. We would be able to determine 11 whether or not a prescription complied with CDC 12 guidelines after we've performed a detailed 13 review.</p> <p>14 Q. Okay. But --</p> <p>15 A. But --</p> <p>16 Q. I'm sorry. Were you finished? I 17 didn't mean to speak over you. Sorry.</p> <p>18 A. I would add that in 2017 and 19 early -- at the end of 2017, we began linking a 20 diagnosis to each opioid prescription, so that 21 would help us to determine if the prescription 22 was linked to an active cancer or a palliative 23 care --</p> <p>24 Q. Okay.</p> <p>25 A. -- opioid prescription. So that</p>

<p style="text-align: right;">Page 178</p> <p>1 would give us a little bit of additional 2 information. But, again, that doesn't give us 3 the full picture, necessarily, all the time.</p> <p>4 Q. Yeah. I think my question wasn't a 5 particularly good one, maybe. What I -- what I 6 was trying to ask is, you couldn't tell 7 anything about the medical appropriateness of 8 MetroHealth prescribers' prescriptions just by 9 looking at the absolute number of pills?</p> <p>10 A. Not necessarily, no.</p> <p>11 Q. You'd have to do the type of 12 drilling down on individual cases that you 13 began to discuss?</p> <p>14 A. To evaluate a particular provider, 15 yes.</p> <p>16 Q. Okay. And you'd need to know about 17 each individual patient?</p> <p>18 A. We would need to have --</p> <p>19 MS. SCOLNICK: Object as to form.</p> <p>20 A. We would need to have additional 21 information to determine appropriateness.</p> <p>22 Q. Okay. And you might even -- you'd 23 need to look at the diagnosis, correct?</p> <p>24 A. And --</p> <p>25 MS. SCOLNICK: Object as to form.</p>	<p style="text-align: right;">Page 180</p> <p>1 Q. Why hasn't MetroHealth prohibited 2 prescribers from writing prescriptions for 3 prescription opioids?</p> <p>4 MS. SCOLNICK: Object as to scope.</p> <p>5 A. Because there are times when 6 opioids are appropriate to treat pain.</p> <p>7 MR. HERMAN: Okay. Thank you. I 8 have no further questions.</p> <p>9 MS. SCOLNICK: Any other questions?</p> <p>10 (No response.)</p> <p>11 MS. SCOLNICK: Okay. This 12 deposition is completed.</p> <p>13 THE VIDEOGRAPHER: Off the record 14 at 2:27 p.m.</p> <p>15 (Deposition concluded at 2:27 p.m.)</p> <p>16 ~ ~ ~ ~</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p>
<p style="text-align: right;">Page 179</p> <p>1 A. And other factors.</p> <p>2 Q. Some of the factors you've 3 discussed earlier, like the risk benefit 4 calculation?</p> <p>5 A. Right.</p> <p>6 Q. And you might need to speak with 7 the specific provider to get additional 8 information?</p> <p>9 A. Right. And a review of their 10 pertinent past medical history and other 11 medications that they're taking.</p> <p>12 Q. Okay. And that's the kind of 13 analysis that a provider should do each time 14 that they write a prescription for a 15 prescription opioid, correct?</p> <p>16 A. Yes.</p> <p>17 Q. Okay. And MetroHealth hasn't 18 prohibited the -- its providers from 19 prescribing prescription opioids, right?</p> <p>20 MS. SCOLNICK: Object as to scope.</p> <p>21 A. No.</p> <p>22 Q. You could write a pres- -- you 23 could write one of your patients a prescription 24 for prescription opioids today, correct?</p> <p>25 A. Yes.</p>	<p style="text-align: right;">Page 181</p> <p>1 Whereupon, counsel was requested to give 2 instructions regarding the witness's review of 3 the transcript pursuant to the Civil Rules.</p> <p>4</p> <p>5 SIGNATURE:</p> <p>6 Transcript review was requested pursuant to the 7 applicable Rules of Civil Procedure.</p> <p>8</p> <p>9 TRANSCRIPT DELIVERY:</p> <p>10 Counsel was requested to give instructions 11 regarding delivery date of transcript.</p> <p>12</p> <p>13</p> <p>14</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p>

<p style="text-align: right;">Page 182</p> <p>1 REPORTER'S CERTIFICATE 2 The State of Ohio,) 3 SS: 4 County of Cuyahoga.) 5 6 I, Stephen J. DeBacco, a Notary 7 Public within and for the State of Ohio, duly 8 commissioned and qualified, do hereby certify 9 that the within named witness, JOAN PAPP, M.D., 10 was by me first duly sworn to testify the 11 truth, the whole truth and nothing but the 12 truth in the cause aforesaid; that the 13 testimony then given by the above-referenced 14 witness was by me reduced to stenotypy in the 15 presence of said witness; afterwards 16 transcribed, and that the foregoing is a true 17 and correct transcription of the testimony so 18 given by the above-referenced witness. 19 I do further certify that this 20 deposition was taken at the time and place in 21 the foregoing caption specified and was 22 completed without adjournment. 23 24 25</p>	<p style="text-align: right;">Page 184</p> <p>1 Veritext Legal Solutions 1100 Superior Ave Suite 1820 Cleveland, Ohio 44114 Phone: 216-523-1313 4 February 8, 2019 5 To: Judith Scolnick 6 Case Name: In Re: National Prescription Opiate Litigation v. 7 Veritext Reference Number: 3216350 8 Witness: Joan Papp, M.D. Deposition Date: 2/5/2019 9 Dear Sir/Madam: 11 Enclosed please find a deposition transcript. Please have the witness 12 review the transcript and note any changes or corrections on the 13 included errata sheet, indicating the page, line number, change, and 14 the reason for the change. Have the witness' signature notarized and 15 forward the completed page(s) back to us at the Production address 16 shown 17 above, or email to production-midwest@veritext.com. 18 If the errata is not returned within thirty days of your receipt of 19 this letter, the reading and signing will be deemed waived. 20 21 Sincerely, 22 Production Department 23 24 25 NO NOTARY REQUIRED IN CA</p>
<p style="text-align: right;">Page 183</p> <p>1 I do further certify that I am not 2 a relative, counsel or attorney for either 3 party, or otherwise interested in the event of 4 this action. 5 IN WITNESS WHEREOF, I have hereunto 6 set my hand and affixed my seal of office at 7 Cleveland, Ohio, on this 8th day of 8 February, 2019. 9 10 11 12  13 14 Stephen J. DeBacco, Notary Public 15 within and for the State of Ohio 16 17 My commission expires September 30, 2022. 18 19 20 21 22 23 24 25</p>	<p style="text-align: right;">Page 185</p> <p>1 DEPOSITION REVIEW CERTIFICATION OF WITNESS 2 3 ASSIGNMENT REFERENCE NO: 3216350 3 CASE NAME: In Re: National Prescription Opiate Litigation v. DATE OF DEPOSITION: 2/5/2019 4 WITNESS' NAME: Joan Papp, M.D. 5 In accordance with the Rules of Civil Procedure, I have read the entire transcript of 6 my testimony or it has been read to me. 7 I have made no changes to the testimony as transcribed by the court reporter. 8 9 Date Joan Papp, M.D. 10 Sworn to and subscribed before me, a Notary Public in and for the State and County, 11 the referenced witness did personally appear and acknowledge that: 12 They have read the transcript; 13 They signed the foregoing Sworn Statement; and 14 Their execution of this Statement is of their free act and deed. 15 I have affixed my name and official seal 16 this _____ day of _____, 20 _____. 17 18 Notary Public 19 Commission Expiration Date 20 21 22 23 24 25</p>

<p style="text-align: right;">Page 186</p> <p>1 DEPOSITION REVIEW CERTIFICATION OF WITNESS</p> <p>2 ASSIGNMENT REFERENCE NO: 3216350</p> <p>3 CASE NAME: In Re: National Prescription Opiate Litigation v. DATE OF DEPOSITION: 2/5/2019</p> <p>4 WITNESS' NAME: Joan Papp, M.D.</p> <p>5 In accordance with the Rules of Civil Procedure, I have read the entire transcript of 6 my testimony or it has been read to me.</p> <p>7 I have listed my changes on the attached Errata Sheet, listing page and line numbers as 8 well as the reason(s) for the change(s).</p> <p>9 I request that these changes be entered as part of the record of my testimony.</p> <p>10 I have executed the Errata Sheet, as well 11 as this Certificate, and request and authorize that both be appended to the transcript of my 12 testimony and be incorporated therein.</p> <p>13 _____ Date Joan Papp, M.D.</p> <p>14 Sworn to and subscribed before me, a 15 Notary Public in and for the State and County, the referenced witness did personally appear 16 and acknowledge that:</p> <p>17 They have read the transcript; They have listed all of their corrections 18 in the appended Errata Sheet; They signed the foregoing Sworn 19 Statement; and Their execution of this Statement is of 20 their free act and deed.</p> <p>21 I have affixed my name and official seal 22 this _____ day of _____, 20 _____. 23 _____ Notary Public</p> <p>24</p> <p>25 Commission Expiration Date</p>	<p style="text-align: right;">Page 187</p> <p>1 ERRATA SHEET VERITEXT LEGAL SOLUTIONS MIDWEST</p> <p>2 ASSIGNMENT NO: 2/5/2019</p> <p>3 PAGE/LINE(S) / CHANGE /REASON</p> <p>4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____ 11 _____ 12 _____ 13 _____ 14 _____ 15 _____ 16 _____ 17 _____ 18 _____ 19 _____</p> <p>20 Date Joan Papp, M.D.</p> <p>21 SUBSCRIBED AND SWORN TO BEFORE ME THIS _____</p> <p>22 DAY OF _____, 20 _____. 23 _____ Notary Public</p> <p>24</p> <p>25 Commission Expiration Date</p>
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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF SEPTEMBER 1, 2016. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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